



NLM 05J00224 3

NATIONAL LIBRARY OF MEDICINE



U.S. NATIONAL
LIBRARY
OF
MEDICINE

DUE TWO WEEKS FROM LAST DATE

1 MAR 9 1956

**L NOV 3 0 1955
SEP 12 1956**

OCT 25 1956

AUG 15 1984

OCT 23 1984

JAN 15 1988

GPO 322808

~~TO
AUTH
DATE
SECURITY OFFICER~~
~~Frank B. Rogers~~

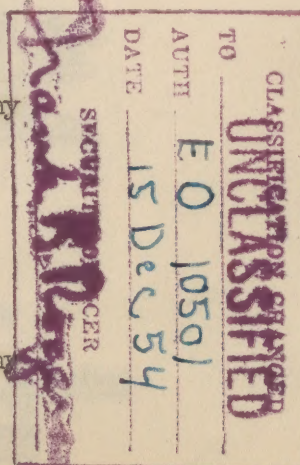
T 2551151

U.S. Dept. of Defense, Committee on Medical and Hospital Services
 of the Armed Forces

TABLE OF CONTENTS SUPPLEMENT REPORT OF (SUBCOMMITTEE)
 ON EMPLOYMENT OF MILITARY MEDICAL RESOURCES

Use of medical Resources

Tab Code		Page	Place Tab on Page
A	Table of Contents	3	3 - 4
B	Introduction	4	5 - 6
C	General Findings and Conclusions	6	7 - 8
D	Recommendations	14	14 - 15
D-1a	<u>Classification and Mobilization of Medical Manpower for the Armed Forces</u>	19	19 - 20
Z1	1. Discussion	19	19 - 20
Z2	2. Factors Involved	20	21 - 22
Z3	3. Classification	21	21 - 22
Z4	4. Mobilization	22	23 - 24
Z5	5. Conclusions	27	27 - 28
Z6	6. Recommendations	31	31 - 32
Z7	7. Letter Extracts and Testimony	33	33 - 34
D-1b	<u>Professional and Military Emergency Training Programs within the Armed Forces</u>	96	97 - 98
Y1	1. General	96	97 - 98
Y2	2. Elements of the Problem	99	99 - 100
Y3	3. Conclusions	105	105 - 106
Y4	4. Recommendations	106	107 - 108
Y5	5. Letter Extracts and Testimony	108	109 - 110
D-1c	<u>General Policies Relative to Assignment on Medical Personnel Including Use of Recognized Specialists and Consultants</u>	174	175 - 176
X1	1. Discussion	174	175 - 176
X2	2. Conclusions	176	177 - 178
X3	3. Recommendations	177	177 - 178
X4	4. Letter Extracts and Testimony	178	179 - 180
D-1d	<u>Replacement Pools of Medical Department Personnel</u>	245	245 - 246
W1	1. Discussion	245	245 - 246
W2	2. Conclusions	245	245 - 246
W3	3. Recommendations	246	247 - 248
W4	4. Letter Extracts and Testimony	247	247 - 248
D-1e	<u>Redeployment and Demobilization of Personnel</u>	283	283 - 284
V1	1. Redeployment	283	283 - 284



UNCLASSIFIED RESTRICTED

RECEIVED
FBI
JAN 23 1948
FBI
JAN 23 1948

AT	1* General Exports and Imports	583	583 - 587
AT	2* Recommendations	583	583 - 587
AT	3* Conclusions	583	583 - 587
AT	4* Discussion	583	583 - 587
<u>Professional and Military Personnel</u>			
D-14	Professional and Military Personnel	583	583 - 587
AT	1* General Exports and Imports	583	583 - 587
AT	2* Recommendations	583	583 - 587
AT	3* Conclusions	583	583 - 587
AT	4* Discussion	583	583 - 587
<u>General Policies Relative to Assessment</u>			
D-15	General Policies Relative to Assessment	583	583 - 587
AT	1* General Exports and Imports	583	583 - 587
AT	2* Recommendations	583	583 - 587
AT	3* Conclusions	583	583 - 587
AT	4* Elements of the Report	583	583 - 587
AT	5* General	583	583 - 587
<u>Planning Problems Arising from the Armed Forces</u>			
D-16	Planning Problems Arising from the Armed Forces	583	583 - 587
AT	1* General Exports and Imports	583	583 - 587
AT	2* Recommendations	583	583 - 587
AT	3* Conclusions	583	583 - 587
AT	4* Discussion	583	583 - 587
AT	5* Factors Involved	583	583 - 587
AT	6* Discussion	583	583 - 587
<u>General Policies Relative to the Armed Forces</u>			
D-17	General Policies Relative to the Armed Forces	583	583 - 587
AT	1* General Exports and Imports	583	583 - 587
AT	2* Recommendations	583	583 - 587
AT	3* Conclusions	583	583 - 587
AT	4* Discussion	583	583 - 587
AT	5* Factors Involved	583	583 - 587
AT	6* Discussion	583	583 - 587
<u>General Policies Relative to the Armed Forces</u>			
D-18	General Policies Relative to the Armed Forces	583	583 - 587
AT	1* General Exports and Imports	583	583 - 587
AT	2* Recommendations	583	583 - 587
AT	3* Conclusions	583	583 - 587
AT	4* Discussion	583	583 - 587
AT	5* Factors Involved	583	583 - 587
AT	6* Discussion	583	583 - 587

UH
390
U56784
1948
C.1

Code	Page	Page
1	1	1
2	2	2
3	3	3

OF THE BUREAU OF MILITARY PERSONNEL RECORDS
OF THE BUREAU OF MILITARY PERSONNEL RECORDS
OF THE BUREAU OF MILITARY PERSONNEL RECORDS

Tab Code		Page	Place Tabs on Pages
V2	2. Demobilization	286	287 - 288
V3	3. Conclusions	289	289 - 290
V4	4. Recommendations	291	291 - 292
V5	5. Letter Extracts and Testimony	293	293 - 294
D-1f	<u>Medical Department Organization from the Standpoint of Personnel, Equipment, Training, and Mission or Tactical Requirements</u>	325	325 - 326
U1	1. Discussion	325	325 - 326
U2	2. Conclusions	329	329 - 330
U3	3. Recommendations	330	331 - 332
U4	4. Letter Extracts and Testimony	332	333 - 334
D-1g	<u>Medical Logistics in Military Campaigns</u>	393	393 - 394
T1	1. Discussion	393	393 - 394
T2	2. Conclusions	395	395 - 396
T3	3. Recommendations	395	395 - 396
T4	4. Letter Extracts and Testimony	396	397 - 398
D-1h	<u>Hospitalization and Evacuation Policies within the Combat Zone and Evacuation to the Communication Zone and the Zone of the Interior</u>	462	463 - 464
S1	1. General	462	463 - 464
S2	2. Elements of the Problem	464	465 - 466
	a. Hospitalization	464	465 - 466
	b. Evacuation Policies	469	469 - 470
S3	3. Conclusions	475	475 - 476
S4	4. Recommendations	480	481 - 482
S5	5. Letter Extracts and Testimony	481	481 - 482
D-1i	<u>Hospitalization and Evacuation Policies within the Zone of the Interior with Special Reference to Construction, Distribution and Staffing of Military Hospitals</u>	541	541 - 542
R1	1. Discussion	541	541 - 542
R2	2. Conclusions	542	543 - 544
R3	3. Recommendations	543	543 - 544
R4	4. Letter Extracts and Testimony	545	545 - 546
D-1j	<u>General Relationships with Other Branches of the Armed Services Relative to Medical Planning and Requirements</u>	588	589 - 590
Q1	1. General	588	589 - 590

288 288 - 289
289 289 - 290

Section 1: The first part of the document
of the first part of the document
 D-17 Section 1: The first part of the document

17	1* Section 1: The first part of the document	282	282 - 283
18	2* Section 2: The second part of the document	283	283 - 284
19	3* Section 3: The third part of the document	284	284 - 285
20	4* Section 4: The fourth part of the document	285	285 - 286

Section 2: The second part of the document
Section 2: The second part of the document
Section 2: The second part of the document
Section 2: The second part of the document

22	2* Гербовый билет	101	101 - 102
27	1* Бессимбиототон	100	101 - 100
23	3* Сербия	112	112 - 112
	Р* Бессимбиотон	103	103 - 110
	У* Нормативизм	101	102 - 100
25	3* Бессимбиотон	101	102 - 100
21	1* Сербия	105	103 - 101
	Домо-от-Бессимбиотон	105	103 - 101
	По-до-Бессимбиотон		

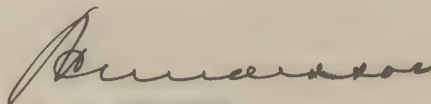
Tab Code		Page	Place Tabs on Pages
Q2	2. Elements of the Problem	591	591 - 592
Q3	3. Conclusions	596	597 - 598
Q4	4. Recommendations	598	599 - 600
Q5	5. Letter Extracts and Testimony	600	601 - 602
D-1k	<u>Factors Contributing to Alleged Overlapping of Medical Functions among the Armed Forces</u>	657	657 - 658
P1	1. Discussion	657	657 - 658
P2	2. Conclusions	658	659 - 660
P3	3. Recommendations	658	659 - 660
P4	4. Letter Extracts and Testimony	659	659 - 660
D-11	<u>The Chief Points or Circumstances within the Military Structure Contributing most to the Apparent Disaffection of Medical Personnel</u>	695	695 - 696
O1	1. Discussion	695	695 - 696
O2	2. Conclusions	696	697 - 698
O3	3. Recommendations	697	697 - 698
O4	4. Letter Extracts and Testimony	698	699 - 700
D-1m	<u>Comments on Medical Planning and Intelligence</u>	782	783 - 784
N1	1. Discussion	782	783 - 784
N2	2. Conclusions	784	785 - 786
N3	3. Recommendations	784	785 - 786
N4	4. Letter Extracts and Testimony	785	785 - 786
E.	<u>Co-ordination Meetings between Subcommittee on Employment of Medical Resources and ...</u>	804	805 - 806
M1	1. Subcommittee on Medical Research	805	805 - 806
M2	2. Subcommittee on Medical Intelligence	807	807 - 808
M3	3. Subcommittee on Medical Services for Dependents	810	811 - 812
M4	4. Subcommittee on Aviation and Medicine	817	817 - 818
M5	5. Subcommittee on Dental Matters	819	819 - 820
M6	6. Subcommittee on Training and Education of Medical Department Personnel	859	859 - 860
M7	7. Subcommittee on Programs for Hospitalization	874	875 - 876

RESTRICTED

25 May 1948

FROM: Subcommittee on Employment of Military Medical Resources
TO: The Executive Secretary, Committee on Medical and Hospital Services of the Armed Forces
REF: Restricted Letter, Office Secretary of Defense, Committee on Medical and Hospital Services of the Armed Forces, subject: Appointment of Subcommittee on the Employment of Military Medical Resources, dated 16 March 1948.

1. The inclosed report is submitted in compliance with instructions contained in paragraph 7 of reference letter.



T. C. ANDERSON
Rear Admiral (MC) USN
Chairman

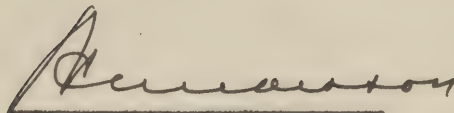
Incls: 1
Report in Quad.

RESTRICTED

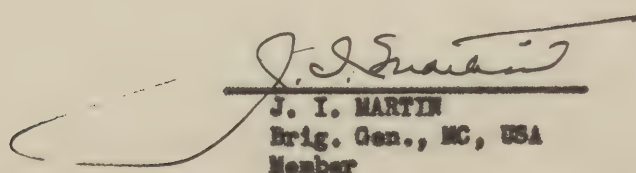
RESTRICTED

**COMMITTEE ON MEDICAL AND HOSPITAL SERVICES
OF THE ARMED FORCES**

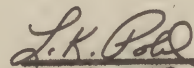
Report of Subcommittee on Employment of Military Medical Resources



T. C. ANDERSON
Rear Admiral (MC) USN
Chairman



J. I. MARTIN
Brig. Gen., MC, USA
Member


L. K. POHL
Colonel, MC
Recorder

RESTRICTED

RESTRICTED
TABLE OF CONTENTS

A. INTRODUCTION

B. GENERAL FINDINGS AND CONCLUSIONS

C. RECOMMENDATIONS

D. SUPPORTING DATA

1. Project Reports with Extracts of Comments

from Letters, Interviews and other Sources

2. Reports of Subcommittee Coordinating

Conferences

RESTRICTED

A

A. INTRODUCTION

1. The members of this Subcommittee have been in daily session since April 1, 1948. The approach to the broad objective indicated of "obtaining at the earliest possible date the maximum degree of coordination, efficiency and economy in the operation of these services" as it is related to "careful considerations ***** given to the areas of deficiency, the operational errors and the malemloyment of our medical resources, etc." has been covered. The desire for provision of the best possible analysis of the controversial aspects, etc., and the procurement of "as many statements or opinions from as many qualified witnesses as practicable in order that impartial conclusions and recommendations may be reached" have been fulfilled to the maximum possible extent during this period.

2. This Subcommittee under the guidance of the Executive Secretary and the Executive Committee has studied the problems indicated, by reference to available pertinent historical and statistical data from the offices of the Surgeon General of the Army, The Bureau of Medicine and Surgery and of the Air Surgeon. As approved at the regular meeting of the Committee on Medical and Hospital Services of the Armed Forces on Tuesday, April 6, 1948, the Letters, Subject: Deficiencies, Operational Errors and Malemloyment of Military Medical Resources in World War II dated 7 April 1948 were sent to selected individuals.

3. A total of 90 individual sources of information have been utilized. The letter replies have been reviewed and opinions extracted. The letter response from various active and former members of the Medical Departments was enthusiastic in many instances. It is believed that very valuable basic material and suggestions have been submitted, from which, if properly referred to, in future planning, much benefit can be derived.

4. The material obtained by interview has been, in certain instances, of the greatest interest and significance. The advantage of direct questioning in regard to certain concepts was obvious. In addition, several officers indicated their desire to express their thoughts in such manner rather than by submitting written comments. A disadvantage of the interviews was the increased difficulty of compiling the data obtained with appropriate placement as supporting information on the particular subject. The time factor involved for all parties

concerned and the overall magnitude of the Subcommittee's task also contributed toward the limitation of the number of interviews held. It is believed interviews should in the future, if held, be restricted to those with experts or most experienced individuals.

5. The Subcommittee reviewed the subject terms of reference being considered by other Subcommittees along with available reports therefrom at hand and coordination meetings were held with available members thereof in all instances in which possible overlapping and problems of mutual interest were deemed existent. The reports of those meetings as held with the Subcommittee members are furnished as supporting inclosures.

6. The source of other material as reviewed and considered appropriate for further study by reproduction, is clearly indicated in the inclosure of supporting data.

7. A total of thirteen main projects have been considered under separate headings and are presented in D. There is considerable interrelationship between the projects in many instances and which allowed only for rather general classification of supporting data. Full consideration should be given that in the process of "breaking down" letter material furnished for consideration under separate subject headings, the sequence, full intent or effectiveness of a correspondent's written information as submitted may well have been lessened in some instances. In such case recourse to the file copy of the correspondent's full letter or report of interview is suggested. Because of the initial approach and wide coverage afforded by the listing of subjects originally suggested, it was not felt that any further breakdown or other change in form for presentation was feasible at this time.

8. It is the Subcommittee's firm belief that a wide general cross section of many qualified opinions has been obtained from various experienced military medical men. In addition, in preparation of the report members of the Subcommittee have drawn upon their own war experiences so as to more fully complement the source material. As presented, it constitutes a variety of diversified opinions which are subject to thoughtful review, analysis and application to each situation. It should be emphasized that the material in no way approaches a complete expression from all possible sources. Under no circumstances should the material be judged as representing a deciding majority vote expression on controversial matters between Force Staff Medical echelons because of the basic Medical Departmental influence on opinion expressed in regard to certain controversial

aspects. Likewise, the importance and worth of statements as made must be weighed as to source and experience, whether hearsay or biased. There is, however, a general trend to constancy in expression of thought on certain phases of the subjects considered and there is a varying degree of conflict of opinions on other phases. It is believed firm and definite corrective action should be initiated in the first instances and that further considered action toward solution of problems of more uncertain status should be resultant from the Subcommittee recommendations as are presented.

9. It has been beyond the scope or possibility of this Subcommittee to give due consideration, analysis and expression of judgment with recommended action for each of the many individual and sometimes detailed recommendations as have been received, extracted and submitted in the supporting data. Many of the points made may be similar or impractical, or well nigh impossible, but, there is evidence of much individual thought and sincerity in most suggestions and meriting a continued reference to and utilization of the material. Procurement of additional details and comment from selected military medical experts from whom specific information may be deemed desirable and an active utilization of the file by Medical Department planning echelons is believed indicated.

10. This report has been prepared and submitted in quadruplicate as directed. The extraction of confidential and frank testimonial opinion from basic material has been the method used as being the most practical to provide the supporting data for each

as have been the subject for varied criticism is based largely upon multiple individual expressions of dissatisfaction to a degree in excess of that which would have prevailed had the opinion been modified by an overall knowledge of the various military medical requirements and circumstances in the various situations which developed.

2. The occasional opinion expressed by various individuals that the performance of the military medical mission during World War II was in all respects very outstanding must be tempered with realization that many times there was far from ideal accomplishment. Chief causes for such were of course, the general inexperience of the Nation in conduct of war of such magnitude, administrative and medical planning difficulties encountered so frequently in command and staff relationships and finally a general lack of clearly defined consistent policies for Medical Department interrelationships, mutual and independent responsibilities and operational procedures.

3. The Subcommittee review of material pertaining to the various subjects suggested has been comprehensive and sincere. In many instances the Subcommittee finds that the corrective action indicated or needed is most obvious but the means of obtaining such is, in turn, most involved and is a proper activity for existing Medical Department Staff sections in the Office of the Surgeon General of the Army, in the Bureau of Medicine and Surgery for the Navy, and in the Office of The Air Surgeon.

4. In general, the Subcommittee, obeying the verbal instructions received toward application of lessons from World War II and their application in the event of a World War III, as it might occur either immediately or eventually, finds and concludes:

a. That for adequate classification and mobilization of Medical Personnel Resources for the Armed Forces, the approach must be with the concept of total war involving this nation as never before; that no single agency exists for determining uniform policy and method in classification of Medical Department personnel for military purposes; and in the procurement of Medical Officers inter service competition and methods held over from World War II and subject to extensive criticism continue in operation with certain disguising variations.

b. That the professional and emergency military training programs within the Armed Forces, as carried out in World War II are subject to moderate criticism and should be revised in accordance with specific recommendations as are made in this report.

c. That the general policies evolving through World War II relative to assignment of medical personnel, including use of recognized specialists and consultants, were initially deficient largely because of inadequate classification methods and procedures. There was progressive improvement in assignments as the War drew to a close, as improved classification procedures were adopted. The quota method of assignment without classification data will recur in the event of another war unless steps are taken to make available classification of all individuals included in the medical manpower resources of the nation.

d. That replacement pools of Medical Department personnel as operated during World War II were one of the greatest causes of wastage of critical doctor and other professional manpower. The Medical Departments of the Army, Navy and Air cannot successfully solve this problem until divorcement of critical Medical personnel administration from non-medical military personnel administration is provided. Decentralized Medical Department authority for making appropriate duty assignments of replacements to the most suitably locally available medical installations is mandatory in lieu of World War II replacement pool operation.

e. Redeployment and demobilization of Medical Department personnel necessarily paralleled for the most part that of the troop elements supported. There is no immediate panacea for the seeming injustices suffered by Medical Department personnel during redeployment and demobilization which will be more effective than uniformity in service overseas requirements and criteria for separation.

f. Medical Department units and organizations from the standpoint of personnel, equipment, training and mission or tactical requirement, developed immeasurably during World War II in the concepts of Force needs therefor. Standardization of certain units subject to common use by Ground, Navy and Air is feasible. Sufficient flexibility must be developed, however, in all medical units to allow for maximum medical support required by the Force concerned. The Medical organizations for the support of combat troops of the Army, Navy and Air should follow a common pattern but with opportunity for adequate provision of specific features desirable and as determined for their own needs by each of the major forces. The general policy for reduction of intrinsic Medical

personnel and equipment with combat organizations and development of suitable cellular units and independent medical organizations to provide adequate medical support as circumstances dictate, is strongly advocated. Planning agencies for the development of specific features of these units as are needed by each Major Force should be activated. Particular emphasis should be placed upon development and procurement of their equipment to be airborne with utilization of common type standard containers for packing and shipping of such equipment.

g. The most urgent of all considerations are those associated with the early stages of the war in the field of medical logistics for military campaigns. Any recurrence of initial phase shortages of medical equipment and supplies as seen in many instances during World War II must be foreseen and avoided. Shipment of medical equipment with organizations being rendered support, will prevent many of the diversions and losses of equipment which handicapped rendition of medical service to troops during the first 12 to 18 months of World War II. Decentralized stockpiling of critical items for immediate assembly and shipment in event of emergency is essential. The necessity for supply maintenance by automatic unit shipment should be limited to the early stages of any campaign so as to avoid wastage of certain unneeded and excess items as will not be used from such shipments. The early establishment in theaters of requisition procedures for exact needs is advocated. The tripartite procedures recommended by the Subcommittee for Medical Supply Depot procurement, storage and distribution methods, would allow for maximum coordination, adequate supply service for each Force concerned and avoidance of duplication.

h. The military medical doctrines and principles as prevailed for evacuation policies and medical care in the Theater of Operations were essentially sound as applied in World War II. With adequate planning knowledge and experienced medical planners superior results were accomplished. The responsibility for evacuation being placed on the next rearward echelon is a sound procedure.

Problems present themselves now in regard to correction of deficiencies as occurred, in thought concepts required in contemplation of newer methods of warfare and probable theaters of operation in event of another war. Clarification of Geneva Convention

and international agreements, better medical support for amphibious operations, new organizations, tentage and other housing necessities for mobile and fixed field medical units, better evacuation direct to hospitals for definitive treatment avoiding repeated transfers through successive hospitals, forceful medical leadership to insure early return of patients to duty status, better troop selection and continued efforts to reduce large psychosomatic patient loads, better medical support for more isolated Air Force units, and need for more adequate communication facilities such as radio between Army ground medical units are examples.

The evacuation of casualties from actual combat areas poses a different problem for each of the major Armed Forces. Units and means required by each will frequently be substantially different. There is ample evidence to indicate that full provision should be made to allow the Medical Department of each of the Armed Forces to develop and operate those facilities required for the complete care of its respective combat and service troops and other supporting elements (civilian) from the time of onset of illness or injury to discharge, separation or retirement from the service. The principles of coordination and inter-dependence for avoidance of overlap, properly employed will eliminate any major objections to such functional necessities and the benefits to be derived from the proper medical support of the Armed Forces concerned, will far exceed some of the minor difficulties which may require solution by adoption of such a program. Thus coordinated evacuation policies and methods for ground combat areas, naval battles, amphibious operations and air participation in combat must be planned and accomplished by the Armed Force Medical echelons concerned. For long range evacuation, the utilization of Air Transport has established itself as a method of choice and to be used whenever possible.

1. It is believed Zone of the Interior hospital planning for a possible World War III should benefit immeasurably from the experience of World War II. Design, location, construction features, designation of numbered Armed Force Hospitals, unified and coordinated effort toward provision of joint hospitalization, avoidance of unnecessary duplication of such facilities, civilian defense requirements, rotation of staff personnel so as to provide medical officers with more professional opportunity, adequacy of debarkation medical centers, convalescent hospitals, control of hospitals and care of dependents are among

the points which are considered. The planning for hospitals in the Zone of the Interior based on strategical concepts of war plans should be made now. Also the desirability of numbering military hospitals as Armed Force hospitals is stressed. The discontinuance of certain descriptive designations of hospitals such as Regional and Station is advocated.

j. The Medical Departments of the Armed Forces in their general relationships with other branches and staffs of the Armed Services relative to medical planning and requirements, experienced great difficulties throughout World War II some of which persist to date. The urgent necessity for joint Armed Force/^{medical} representation in the office of the Joint Staff of the Joint Chiefs of Staff is considered probably the most important single conclusion arrived at by this Subcommittee and recommendation is made accordingly. In all echelons, information was all too frequently far less than that necessary for adequate and proper medical planning. Operational control of large medical installations with a medical department mission only, was frequently conducted with great interference from military agencies which had no responsibility in regard to the primary mission, but authority to a degree entirely uncalled for.

k. Factors which are alleged to have contributed to overlapping of medical functions of the Armed Forces are reviewed. The importance of determining the competency of the critic is deemed most necessary. The desirability of joint and coordinated efforts is recognized and urged, but caution is believed indicated in the initiation of any changes which will eventually result in an inadequate intrinsic medical support for any single Armed Force of the Nation, as may be required for it to satisfactorily accomplish its mission.

l. Procurement methods, duty assignments, rank and promotion, unkept promises, undesirable family and housing conditions, class distinctions, lack of professional opportunity for advancement, dislike for regimentation, medical care necessary for civilian dependents, and the disparity of income between military and civilian doctors are among the causes of disaffection mentioned. It is concluded that much can be done by the military medical establishments to minimize causes for disaffection among civilian doctors serving with the Armed Forces in another war. Action is indicated to adopt the necessary corrective policies and measures now which will remove causes for disaffection.

m. Other conditions which in the light of past experience are believed to merit consideration in order to obviate the repetition of mistakes in the employment of military medical resources have been reviewed by the Subcommittee. They relate to Nursing Corps difficulties, training of doctors for the military service in Military Schools of Medicine similar to West Point and Annapolis, civilian defense, medical intelligence information, reduction of paper work, medical aspects of military government activities in foreign countries, and application of the principles of Navy General Order No. 245 for control of larger medical installations. They are mentioned as constituting individual problems not previously dealt with under other subjects.

The Subcommittee, with the exception of the medical member representing the Air Surgeon wishes it understood that in using all terms in reference to the Medical service of the Air Forces in this report, that it does so without implication that it favors the creation of a separate Medical Department for the Air Force in the future. It has interpreted the terms of reference for its investigation to exclude a study with recommendations in that area.

C. RECOMMENDATIONS

The Subcommittee on Employment of Medical Resources recommends:

1. The establishment of joint medical sections on the following agencies:
 - a. National Security Resources Board
 - b. Central Intelligence Agency
 - c. Joint Staff of the Joint Chiefs of Staff
2. The adoption of the concept that in the future, medical personnel resources will and must be controlled nationally and that no single using agency can expect to secure its requirements by individual divergent action.
3. The establishment of a national registry of all medical personnel resources by the National Security Resources Board.

Action to eliminate the following:

- a. Competition by each of the services for the procurement of medical personnel.
- b. The volunteer system used in the past for securing medical personnel during mobilization and war.

4. Adoption of a single uniform method for designating the classification of each category of medical personnel.

5. Action to effect the following:

a. Full use of non-professional officers in administrative positions in all medical facilities in peace and in war. #42 #39

b. Greater use of the female components of the services in ZI medical facilities in peace and in war.

6. A thorough study of the present reserve systems of the services to determine their worth and proper method of operation under a policy of national control of medical resources.

7. The continuation of the affiliated unit program with reduction in the professional assignments to "key" personnel only. #7

8. The immediate creation of a permanent joint service medical institution as described in the body of this report and in Conclusion No. 16. (Project - b).

That the creation of a permanent joint service institution for the collection, evaluation, publication and dissemination of current and future research and development in the fields of military and naval medicine and surgery, preventive medicine, medical aspects of atomic and biological warfare, is a prime necessity of the moment for the peacetime and emergency training of all medical personnel, civilian and service.

That highly trained civilian and service personnel are indicated to comprise the faculty of this institution.

The active pursuance of every possible effort especially with civilian medicine to advance the training of civilian practitioners during peace to better equip them for service in the event of war.

9. The inclusion in the specific plans for training of medical personnel for future emergencies of the training facilities and methods used by the services during World War II, with the necessary indicated minor improvements especially in the indoctrination field of newly joined officers. #17 #37 #38

10. Staff action to insure full control of all medical replacements by the Chief Surgeon in any area to eliminate the serious misassignment of medically trained technicians that occurred in World War II in replacement depot practices and thus prevent the wastage of training effort and scarce category medical skills. #21

11. The constant and intimate liaison between Medical Departments of the services with their general staff agencies which are now planning for emergency training in future mobilizations.

#24 #44 #45

12. That adequate provisions be made immediately to train selected regular medical officers during peace for a career specialty in staff and high command assignment in war.

13. That action be taken to insure that all Medical Department personnel in Replacement Pools are without delay made subject to assignment by the Medical echelon in the appropriate Command level, at all times in highest priority status for Medical and Dental Officers and utilizing the practice of temporary overstrength in existing Medical installations.

14. That assignment of officers to units should be made as soon as possible on an alert basis in event of emergency and that critical professional personnel be allowed to remain in civilian status until the last possible moment and then be moved to duty assignments by high air priority. That in order to enable this concept in practice definite representation for air means is imperative.

15. That in future war planning be completed early for the rotation, redeployment and demobilization of medical personnel; that the point credit system used in World War II for service be further developed and retained for the rotation of general medical service personnel from theaters of operation to Zone of Interior, but that it not be adopted without modification for specialist categories depending upon their replacement availabilities.

That rotation between civilian and service status during war be not considered as practical except in the case of scarce category specialists.

That the Surgeon Generals of the Armed Forces be given the authority to determine the criteria for discharge of medical personnel based upon their post-war medical service requirements.

That sufficient time be allotted in the demobilization discharge process for a proper type final physical examination.

That coordinated action by the Army, Navy and Air Forces to equalize wartime service of their medical personnel be provided.

16. That steps to gain the necessary authority to more forcefully utilize higher priority air and available medical transport facilities in war for the movement of medical personnel be taken NOW.

17. That every effort be made through medical sources to educate the public and its representatives of the folly of demobilizing the armed forces and its medical services in a similar fashion that occurred in World War II.

18. That each Armed Force planning agency for the medical support thereof extend coordinated and joint effort to effect the following:

- a. Designation of Medical units necessary for immediate support of their Combat and service troops in the Zone of Interior and in Theaters of Operation.
- b. Determination of units and organizations with their structure, which may be standardized and subjected to mutual interchangeability usage.

19. That necessary appropriations be procured to insure the development and earliest possible procurement in event of war of standard equipment for Medical Department use most suitable for air lift. That the agencies now involved in such work be provided most able and experienced personnel. That coordinated joint efforts in that direction be stimulated to the utmost by each of the Medical Departments. That the Air Force facilities, their previous experience and cooperation in effort should be utilized to the maximum by Medical representatives.

20. That tentage, construction features of medical installations, utilities and their maintenance, receive intensive study and effort to prevent deficiencies as occurred in connection therewith during World War II.

21. That suitable radio equipment and personnel be added to the tables of organization and equipment of all field medical units which normally operate in the Army Service area.

22. That plans be developed for the orderly procurement of the medical equipment and supplies needed by the Armed Forces in the event of a future war.

23. That the present group of experienced medical supply officers be maintained by the intensive training of new officers in the system developed in World War II. *17

24. That an Army-Navy-Air Force Medical Department board be organized and assigned the responsibility of formulating plans for the supply of the whole blood from the United States to overseas theaters in the event of war.

25. That further immediate and detailed studies by competent joint armed service medical personnel are mandatory in the following fields:

- (a) The implications of atomic attacks on large overseas bases as it involves the medical services.
- (b) The determination of our future status regarding the provisions of the Geneva Convention and allied international agreements for the protection of the helpless. This study to include a means for the indoctrination of all Armed Forces personnel as to that determined status.
- (c) The development of sound doctrine and methods of procedure to cope with all of the medical aspects of amphibious warfare. This study to include covering the entire field of floating medical evacuation transportation.

26. The development of a better system for the control and use of hospital ships during war.

27. That action be taken by the Surgeon Generals to sufficiently increase the number of medical facilities in the Combat Zone to permit of the salvage of medical type cases in those areas.

28. That staff action be taken by the Surgeon Generals to insure the improvement of hospital construction procedures by the Corps of Engineers in Theaters of Operation over World War II practices.

29. That necessary staff action be taken to set up a joint Army, Navy and Air Force project for the development of better types of ambulances for land, sea and air medical use.

30. That more and better consideration for hospitalization needs of Air Force troops in isolated regions is indicated and should be provided.

31. That joint Armed Forces planning be instituted for standardization of common fixed and mobile hospital unit requirements. That a study be made to investigate the feasibility of changing of designation of Armed Force Hospital as practiced in World War II. That a numerical designation with standardized policy for type and location is indicated.

32. Initiating medical military hospitalization planning on National Military Defense level required to coordinate military and civilian defense in the event of total war involving the United States.

33. To provide for military medical Armed Forces (Army-Navy-Air) hospital planning in conjunction with Joint Chiefs of Staff War Plans and Strategic Concepts.

34. That action be taken by the Surgeon Generals of the Armed Forces by proper staff methods to:

- a. Assure their position in wars of the future on the proper staff level.
- b. Assure the position of Chief Surgeons in Theater of Operations on the proper staff level.
- c. Press the adoption by the Army and Air Forces of the Navy system of supervision and control for their respective medical installations as prescribed in Navy General Order 245.

35. That action be taken by the Surgeon General of the Navy by proper staff methods to:

Assure the establishment of a medical section in the headquarters U. S. Marine Corps.

36. That considerations and recommendations of existing Subcommittee projects many of which are now operating with concepts of peacetime needs only, be analyzed fully as to their potential adaptation in the event of another National Emergency. That any peacetime unification and consolidation of activities of the Medical Departments for the Armed Forces as are implemented for existent economical reasons, be approved or accomplished only after full certainty and agreement is established that an adequate Force identified Medical Department may still evolve and be capable of rendering necessary and adequate complete Medical service to the arm it serves.

37. That "unified and coordinated effort" be adopted as the guiding principle of the respective Medical Departments of the Armed Forces, but that any further stressing of unification and one Medical Service objective be tempered in order that continuance of the historically demonstrated efficiency and accomplishments of the Army Medical, the Navy Medical and potentially the Air Medical Departments may be insured, and their complete absorption of identity eventually in a civilian controlled agency, can be prevented.

38. Policy definition to allow for maximum administrative and operational control of medical department activities and particularly medical personnel management by the Medical Department of the Armed Forces concerned.

39. Continuing Armed Forces Medical Departmental analyses and corrective action indicated against those conditions which caused disaffection as are reported and available in detail by perusal of the supporting data.

RESTRICTED

D-1a. CLASSIFICATION AND MOBILIZATION OF MEDICAL MANPOWER FOR THE ARMED FORCES

1. DISCUSSION

Full realization of the importance of medical service to the Nation in future war has not been sufficiently achieved in military or civilian spheres, nor will it be until sound presentation of its importance has been made on a national basis. Our medical resources are limited. It is imperative that they be used most economically if we are to avoid defeat in the face of a greatly expanded need which future war is sure to demand. The concept of "total" war wherein our homes and families are prime targets for destruction, the advent of atomic weapons, the developments in biological warfare and the reduction of the former military obstacles of distance by guided missiles and latest aircraft, all presage the need for medical services far in excess of any experience of this Nation and demand centralized control over all medical resources. The attack without warning of one or more of our large industrial or other important centers would pose a medical problem distinct from any purely military plane for national defense. This phase of providing medical service to large segments of our civilian population is currently considered as a local civilian responsibility. It is patent that provision for adequate civilian medical means to cope with any local catastrophe can only be assured by consideration of those needs in national planning for use of medical resources. Civilian medical defense needs therefore loom for the first time in our history as an important factor in the distribution and use of national medical resources. However well implemented local medical plans may be, our present location and distribution of civilian and governmental medical facilities to cope with a catastrophic attack are far from ideal and mitigate against reliance on local independent action. This fact indicates the need for practical plans to enable the shifting of medical resources rapidly on a nationwide basis. This connotes the prime demand for a nationally controlled medical service. To implement this concept, there must be formed at the earliest date possible a medical group on the National Defense level. Further, because of the extreme importance and manifold facets which national medical coverage presents, it is clearly indicated that medical sections must be established immediately in all national agencies concerned with the control of medical effort. The selected officials to form these medical sections must be eminently qualified to discharge their duties. The Committee believes that civilian practitioners should be selected for these assignments as well as medical officers from the armed services. To attempt solving this immense medical problem on any other basis is useless and can result only in a return to our past methods of divergent, wasteful and expensive efforts by each agency concerned in national defense and security.

RESTRICTED

RESTRICTED

Unless a definitive medical plan is developed NOW for an adequate medical service in all spheres and that plan is implemented by practical means and methods from a national level, the possibility of a major catastrophe to the public's confidence in medical leadership and service early in any international conflict is more than simple conjecture. This factor alone might well result in a national psychology that would accept early and complete defeat.

The research of this Committee has established evidence of the need for some form of legally required service of medical personnel resources in war. This forms the keystone of a process which, if soundly developed by law, will permit equal and just national service of the individuals who comprise American medicine.

Medical manpower resources are not constrained to the physicians, dentists and veterinarians of the Nation. Full consideration in studying medical resources must be given to the medical ancillary groups so important and essential to modern medical practice. Our resources in nurses, dietitians, prosthodontists, physio-therapists and occupational therapists, clinical psychologists, social workers, laboratory technicians, and many other groups must be controlled on the same national basis as doctors. One national medical agency should control the resources of the entire group.

This Committee has not considered the present procurement of medical personnel for peacetime needs as falling within the purview of its directives. It cautions against the establishment of any rigid system of peacetime procurement which cannot be rapidly discarded if necessary or changed to smoothly fit into the system recommended for total mobilization of medical personnel resources for war.

II. FACTORS INVOLVED IN THE PROBLEM

1. REQUIREMENTS

a. Composite national medical personnel requirements can only be determined after each using medical agency concerned in a total war effort has screened its individual needs. Individual requirements must be based on present and projected needs and on well conceived plans patterned with the knowledge that our resources are limited and that only the strictest economy of them will permit of adequate medical care in a global war. These plans, as far as the Committee has been able to learn, do not exist at the present. The first step indicated, therefore, is direction from a national level that these plans be prepared and submitted. The second step will be the careful scrutiny of the demands of each of the using agencies by a competent national medical group which must be empowered to make decisions leading to a practical allocation of the available resources.

b. Full consideration must be given to the needs of the many medical activities which are not at present organized to present their

RESTRICTED

RESTRICTED

requirements in a unified manner, such as the medical teaching institutions, State, County, and Municipal Health Departments, Industrial medicine expanded for war production, etc. Each State should be required to submit its minimum requirements for the adequate care of its citizens during war.

2. RESOURCES

There is no single agency now in existence which has or maintains a complete registry of the medical personnel resources of the Nation. Until such data is accumulated and maintained nationally on a current basis no worthwhile or efficient overall or specific allocation of resources can be made to any using agency or community. A comprehensive and all-inclusive survey is indicated NOW. National machinery to effect this first important step to a rational distribution and use of our medical manpower resources should be established NOW. Without adequate legislation which would compel individuals concerned to furnish initial and subsequent periodic reports on their qualifications and status, the undertaking would prove worthless. The entire problem resolves itself principally into the immediate establishment of a Governmental agency which will establish and maintain a national registry of all groups involved in the spheres of medical resources.

In the pursuance of strict economy of medical manpower in any future war, individuals once registered should be protected by law from call and assignment to any service other than the medical. Also, they should, by the same legal restrictions, be prevented from voluntary service in other than medical assignments. Once tagged, they should only be released by the national agency in control of medical resources.

It is logical that this projected national agency should be established as a section of the national Security Resources Board.

III. CLASSIFICATION

It is generally agreed that an accurate determination of the skill and potentialities of any individual cannot be made solely on the basis of his or her membership in or by certification of any medical group or organization. Neither can full reliance be placed on the statements of over-zealous individuals. The status of each specialist can only be established by the full investigation of all sources of information in each case. The same law which requires registration should include teeth to compel individuals to present only facts concerning their qualifications.

Classification in past emergencies has been made by each of the armed services often on a hurried and unscientific basis. This has been a factor in wastage of medical skills. Further, there has not been a uniform method of designation for various gradations of particular medical specialists or skills. The system currently used for this purpose by the Army has met favorable concurrence by the other services and might be offered for adoption nationally. Prior experience in one of the armed services can be coded as part of the classification. Apart from the classification

RESTRICTED

RESTRICTED

of skills, it is necessary to classify medical manpower on a physical basis. This is necessary to avoid wastage and misassignments. In general, it is agreed that the military services can utilize but a small percentage of the age group over forty-five and of those otherwise physically handicapped. The Army classification of "limited" military service for medical personnel proved to be sound and should be adopted on an identical basis by all of the armed forces. Just what the standard should be for "limited" service involving practitioners has brought forth many varying comments. Most are agreed that less stringent physical requirements should be established for any further emergency.

Contrary to general belief, there are many civilian physicians who are qualified for and prefer medical administrative assignments rather than professional ones. These should be specifically classified as to their desires in the proposed national registry and called into service only when needed.

It has been suggested to the Committee that pre-induction classification of medical technicians would be a big step forward in mobilizing that group of medical resources. While an admirable idea, the magnitude of the problem on a nationwide scale mitigates against its consideration as an immediate requirement. However, it should be retained as a very important matter for National Security Resources Board and Selective Service System to consider in improving upon World War II practices. It is but part of the process which should be operated for the classification of all skills prior to actual induction.

The most important individual in the medical services of the armed forces in war is the medical officer who serves with the combat troops. He truly is a specialist of the scarcest category and should be so classified and given additional recognition in the form of pay for his hazardous assignment. His knowledge and application in rendering the initial care to the sick and wounded as well as in preserving the health of his unit plays a large part in determining the outcome of battles. These officers must have military training and therefore must be called into the armed services earlier than other doctors. They must be young and physically in their prime besides possessing moral strength far beyond that required for the stay-at-homes and those who work in rear areas. It has been suggested by some that all of the armed services adopt a special classification for this category of medical officers. The committee concurs in that suggestion as most praiseworthy and just.

IV. MOBILIZATION

a. GENERAL

The essence of preparedness and the key to mobilization for national effort is the exact knowledge of and the ready availability under legal rein of medical personnel resources. The first step and the most important in mobilization will have been completed with the establishment of a national registry of medical personnel resources as previously suggested. The system established for the control of the actual calling into the Armed services of individuals must be rigidly controlled. No system can be

RESTRICTED

RESTRICTED

effective unless it is solidly built on detailed plans of each of the using agencies. Prowar assignments of personnel will obviate the chances surely to recur unless scientific approach is made to this problem. Absolute authority must be vested in the Surgeon Generals of the Service to determine the time of call of its allotted medical personnel. Interferences caused by blanket regulations or calls made by non-medical personnel staffs or sections cannot be permitted. Good planning should prevent that.

Wash complaint has been made by practitioners who had war service over the long initial period of professional inactivity which occurred in their experiences after their call as individuals, and particularly by those in reserve units after the call of their units into active service. Doubtless there is much truth in these complaints. To reduce this wastage to the absolute minimum should be the goal of all service medical planners. In essence we should strive to call practitioners into service only when needed either to practice their professions or to give them the minimum of training they require to accomplish their assignments proficiently. There will always be debate as to the amount of training the civilian needs to assume service duties. It cannot be generalized at this period, not only in medical fields but in all others. Better classification of civilian practitioners and better plans for the phasing in of all medical resources are the two keys to reach a reasonable goal in the future. In considering the problem it is well to never lose sight of the fact that our enemy has always in the past had a great deal to do with the conduct of war. Our planning will be subject to change, often major in scope, which will affect the medical effort and oftentimes produce overages in some areas while shortages exist in another. These are the fortunes of war and are shared by the fighting arms in the same proportion as in the medical services. Medical men will be wanted to the extent that these fortunes dictate. It cannot be avoided by the consideration of post-war complaints, nor can measures to anticipate and prevent some of that wastage be devised or taken without supernatural aid.

It has been stressed consistently by testimony and evidence given this Committee that criticism of the record of the medical services in World War II is most unjust and baseless in any of the major fields. Further, the petty complaints investigated oftentimes infer that the inefficiency of so-called medical "brass" was the sole cause of wastage and disaffection and that the replacement of these blunderers and incompetents in war by civilian practitioners of outstanding professional qualifications would insure a pleasant and professionally instructive period of military service for each and every doctor. The falsity of this gibberish is too obvious to require further comment.

b. VOLUNTEERS

Facing the implications of "total" war, there can be no longer the dependence for an adequate national medical service on a system based upon the whim of the individual practitioner. There is no denial that our World War II mobilization was too rigid, especially in the calling to

RESTRICTED

RESTRICTED

duty of medical officers. A large part of the wastage that ensued can be traced to the volunteering of individuals for immediate service. While admirable in concept such a process is illogical and if continued, will prove again to be the key block to efficiency in the desired process of calling only those needed according to planned needs. It was a prime factor in crippling local civilian medical needs.

c. THE DECARLIZED RESERVE SYSTEM

There can be no nationally controlled system of the desired universal medical service without revamping our present organized reserve systems in the various armed services. We cannot face a national emergency of the future and cope with it on a voluntary service basis which forms the keystone to the present organized reserve systems. As much as we dislike regimentation in any form it must be accepted as the only sound method of insuring full medical coverage of the nation in the future. Conditions far different from previous experience compel its adoption.

Once national registry has been accomplished and plans projected, it is essential that each individual be earmarked during peace to his role in war.

The question of rank enters into the present Reserve systems and has provided a great deal of dissatisfaction among medical personnel. It might be said that those individuals who voluntarily accepted reserve commissions in great numbers of instances found themselves stymied in promotion at the expense of those other comparable individuals who preferred to wait until war developed and then bargained with the services for higher rank. This system must be discarded as its only result will be the refusal of personnel to join the reserves during peace. Further, one of the purposes of organized reserve units was to afford peacetime training in military duties. The results were very questionable in most minds and did not justify the expense and time involved. Further, medical reserve units were broken up early which proved the assertion that the Medical Department in many instances, did not plan properly for war. There is much truth in that.

d. THE NATIONAL GUARD

These military units have a dual function and must be considered in a special category in the matter of assignment of medical manpower. They must remain on a voluntary basis with due credit in quotas being given by the national medical resources assignment authority.

e. AFFILIATED UNITS

There is universal accord in the need initially for affiliated units in the Army, principally because they form the best medical reserve which is capable of assuming immediate duty in the event of national danger. This concept is further anchored by the threat of atomic attack on this country without prior notice or the initial jolt of a future war. It is the

RESTRICTED

RESTRICTED

consensus of most that these units which previously contained the best and often the only qualified professional skills of an institution should be revamped to include only key professional personnel. Further, that when called for training purposes in war that only the minimum essential of that key personnel be called initially and that the strictly professional staff be added from other sources and called into service at the latest possible date prior to anticipated functioning of the unit.

f. TITLES

There is considerable merit to the suggestion that all medical personnel when called from civil life to duty in war be titled Surgeon, Assistant Surgeon, Jr. Assistant Surgeon, or some other non-military title. Pay grades and promotions might be established on an equitable basis. This idea, while commendable, would, in the opinion of the Committee, only serve to widen the gap between regulars and reserves and thereby result in a further increase of criticism of command.

g. ASSIGNMENTS

Prewar earmarking of medical personnel in every possible case based on detailed plans will eliminate most of the difficulties encountered in World War II in this field. Medical units where needed should be designated in plans and need not necessarily be organized until needed in a reserve status. Key officers should be advised prior to war of their prospective assignments and then actually placed on those assignments when phased into the services.

Most humans have preferences for services either on land, on the sea, or in the air. This must be realized in the assignment of medical personnel. Unlimited interchangeability of assignments between the armed services is not sound in planning or practice, but may be necessitated by the exigencies of war.

Any guarantee of freedom from service on the land, on the sea, or in the air is unthinkable as it would set up a serious discriminatory factor. Hence this problem can best be covered in the registration and classification process by demanding that a preference be stated by each individual for a branch of service.

Experience in World War II firmly established the feasibility of utilizing qualified medical, dental and veterinary officers in command and staff positions. Many of these assignments proved unpopular both with the individual concerned and with reserve component subordinates who felt themselves better qualified, usually professionally. Regardless of the concept now current in some of the services that in the event of mobilization a large percentage of regular medical officers would be retained on strictly professional assignments, it is believed after mature consideration of the entire problem that such a concept is without a firm basis and will not prove sound on trial. Penicillin Armies and Navies have been retained by this Nation only to guarantee that a firm nucleus be ever present around which a national mobilization might be built. The services have been always charged with a

RESTRICTED

RESTRICTED

definite and inescapable responsibility during peace years to prepare themselves for war. The Medical Departments of the services can in no way avoid that important mission by falling back on any promise which overwhelmingly adopts the professional care of peacetime military and naval personnel as their principal mission. The fact that training is necessary for the development of medical leaders for war service can not be questioned. There is no agency other than the services which can provide the means for that training. Civilian practitioners can not be expected to spend years away from their civilian avocations for that type of training. Therefore, the training must fall to the lot of regulars in the services. Training of Medical Department regulars for their war assignments in the command and staff fields is a goal and should be given paramount consideration now. The implementation of a program for the training of these officers is considered in another section of this report.

RESTRICTED

RESTRICTED

III. CONCLUSIONS

The Committee concludes:

1. That until a national registry for each category of medical personnel resources has been established and kept current, our total medical resources will be unknown and the best allocation of these personnel will be impossible in any future national emergency.

That each qualified individual so registered should be considered a member of the National Medical Reserve and called into service without recourse to the onus of conscription.

That failing the adoption of this measure, there must be conscription of doctors in future war.

That because of the import of "total" war, the civilian need for doctors in the United States will for the first time in our history be greatly increased and will require careful and judicious control to avoid chaos.

That this requirement will materially lessen the availability of doctors for duty with the armed services.

That a balance between civilian needs and military requirements must be made.

That Federal control of medical resources is imperative if we are to equitably allot our meagre resources in war.

That to enable Federal control, a new medical agency is indicated in the national Government on a proper level, and

That this agency should be largely composed of able and qualified civilian and military medical leaders.

That this agency should be vested with authority to allot the national means in all the areas of medical service.

That for practical reasons it seems best to place this new medical agency as a section in the National Security Resources Board.

That legislation is necessary to secure data for the proposed national registry of all medical personnel resources.

That this legislation should compel individuals to furnish reliable data on a similar basis to income tax requirements.

2. That the mobilization process must follow specific and detailed plans which should be available now and well in advance of any mobilization. These plans do not exist in sufficient detail at present to pre-

RESTRICTED

RESTRICTED

vent a recurrence of many of the pitfalls which were apparent in World War II.

That there can be no system designed which will totally eliminate wastage. However, it can be minimized during mobilization by proper planning which will prevent not only the overcalling of personnel at any time, but also will prevent calling individuals in too early.

3. That too few dental resources were available early to cope with the enormous amount of work necessary to place military personnel in acceptable dental health for combat service.

That this field deserves intensive study and corrective action by the dental chiefs of each armed service.

4. That a single coding system for the designation of the classification of practitioners should be established nationally.

That until this is accomplished, confusion and misassignments of resources will continue.

That the medical services of the Armed Forces should at this time agree upon and set up a similar system as a proposed one for national adoption.

5. That within reason, every effort should be made to advise doctors of their planned war assignments during peace. This will afford them the opportunity for some preparation and assurance that his or her services will not be unduly wasted.

6. That the reserve system of the various armed forces as currently operating are in need of intensive study and change where necessary to fit into the scheme of national control of medical personnel resources.

That for the time being, there appears to be no necessity for a complete abandonment of the reserve systems.

7. That the retention for the time being of affiliated medical units of the Army is indicated, principally because of the desirable feature which enables their use in emergencies. However, it is the consensus of all that they should have only "key" medical personnel assigned when called into active service.

8. That consideration should be given to the suggestion for a change to a uniform titular designation of doctors called into the service during war, but that until a better plan is devised that the military and naval ranks in use currently be used as in the past.

RESTRICTED

RESTRICTED

9. That in future mobilizations of medical manpower more attention and care will be necessary in calling personnel from civilian pursuits.

That in principle no one should be called prior to the earliest date his professional services are needed or for the minimum training period which is essential in his contemplated particular assignment.

10. That misassignments and certain wastage of doctors did occur during World War II. That in most instances glaring examples of these defects were the result of situations beyond the control of planners and medical commanders.

That in future wars we must expect identical situations and the same type of complaints.

That all possible measures should be taken in medical planning and in execution to minimize personnel wastage.

That while improvement is undeniably indicated in our personnel management and should be attained, no onus should be attached to our wartime medical leaders which is based upon the hindsight observations of unqualified observers.

11. That current surveys and studies of tables of organization and equipment for medical units of the armed forces for the purpose of making fuller use of non-professional personnel, including females, in the administration of these units should be continued.

That non-regular medical officers, even though they prefer administrative assignments in the services during war should not be used on non-professional assignments except in the necessary medical command and staff positions.

That active qualified practitioners should not be permitted to volunteer for wartime service in any of the other services or arms.

12. That to insure full coordinated effort in the use of national medical resources it is necessary to establish medical sections in the following agencies of the National Military Establishment:

- a. National Security Resources Board
- b. Central Intelligence Agency
- c. Joint Staff of the Joint Chiefs of Staff

13. That further competition between armed forces medical services in the procurement of medical personnel is unsound in light of the dictum from superior authority that every possible coordinated effort be made.

14. That rotation of non-specialist medical officers between field and hospital units in war must be accepted as a "must" to obviate the justifiable criticism of medical officers that they regressed professionally because of their lengthy field assignments.

RESTRICTED

RESTRICTED

That all classes of medical officers, including specialists, should be rotated to the greatest practical extent between theaters of operation and Zone of Interior medical facilities.

That these measures cannot be accomplished uniformly without specific plans to implement necessary general directives that need to be issued concerning this problem.

15. That regardless of the concept that regular medical officers will be retained on strictly professional assignments during war, that it will not be possible to do so except in a minor way.

That the large demand for command and staff medical officers in war cannot be adequately met from civilian sources of these rare categories and further,

That civilian medicine will not react favorably to any system proposed wherein civilian practitioners will be required to assume more non-professional assignments than in World War II.

RESTRICTED

RESTRICTED

IV. RECOMMENDATIONS

1. The Subcommittee recommends that the following be accomplished in the order listed:

a. Adoption of the concept that in the future, medical personnel resources will and must be controlled nationally and that no single using agency can expect to secure its requirements by individual divergent action.

b. Establishment of a joint medical section consisting of senior qualified medical officers of each of the three services with necessary assistants on the Joint Staff of the Joint Chiefs of Staff. (See Tab J).

c. Establishment of joint medical sections on the following agencies:

- a. National Security Resources Board
- b. Central Intelligence Agency
- c. Joint Staff of the Joint Chiefs of Staff

d. Establishment of a national registry of all medical personnel resources by the National Security Resources Board.

e. Action to eliminate the following:

- 1. Competition by each of the services for the procurement of medical personnel.
- 2. The volunteer system used in the past for securing medical personnel during mobilization and war.

f. Adoption of a single uniform method for designating the classification of each category of medical personnel.

g. Action to effect the following:

- 1. Full use of non-professional officers in administrative positions in all medical facilities in peace and in war.
- 2. Greater use of the female components of the services in all medical facilities in peace and in war.
- 3. A thorough study of the present reserve systems of the services to determine their worth and proper method of operation under a policy of national control of medical resources.
- 4. A study of the feasibility of controlling the rotating of medical personnel by definitive top level directive on field and hospital duties.

RESTRICTED

RESTRICTED

h. Continuation of the affiliated unit program with reduction in the professional assignments to "key" personnel only.

i. No changes to be made in the policy of giving military and naval titles to practitioners while on duty in the services.

j. For planning purposes under present conditions that all regular officer medical personnel be considered available for command and staff assignments in the event of war.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. C. Greaves (MC), USN
dated 17 April 1948)

***** (a) One criticism frequently heard was that all qualified men were not used efficiently, or were used in ways that were not to their credit, or advantage to the service. It is one that is probably very difficult in resolving to the satisfaction of everyone. The Medical Services were interested in assigning qualified men to important specialist billets. The difficulty was that there were more specialists, who were qualified in their own estimation for the better billets, than there were billets. It might be proposed, therefore, to establish a system of classification of specialists on the basis of their training and experience, and to similarly classify billets in medical activities. Such a classification should be made a routine, with the results published to the individuals and institutions concerned, and based upon a standard of measurement drawn up by a recognized group of authorities. Thus, the best qualified men would be assured of being assigned to the most important billets and the billets would be certain of being filled with satisfactory men, at all times. It is realized that this policy was followed, more or less, in World War II but the way in which it was carried out appears to have created the impression in the minds of many that favoritism was being used and any suspicion of favoritism is always detrimental to morale. A classification system approved by leaders of the profession would tend to destroy such suspicion on the part of men who are highly qualified in their specialties but who do not happen to be on the staffs of renowned civilian medical institutions.

*Efforts should be intensified to enroll civilian physicians in the Reserve Corps. It is questionable if this will produce enough results to insure a satisfactorily balanced Medical Service in the event of another emergency. This statement is made on the basis of conversations with civilian physicians. They are not interested in aligning themselves voluntarily with a military organization with the prospect of having to serve periods of active duty in a mobilization for political and diplomatic effect. The alternative is Selective Service registration of all civilian physicians under a certain age and the organization of a Selective Service Medical Reserve. Such

REC
L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. C. Greaves (MC) USN
dated 17 April 1948) - Continued

a program would permit an orderly allocation of the available medical manpower to civilian and military needs and would avoid a haphazard program should the nation be confronted with a sudden major emergency. Selectees for military service could be assigned to duty in the service of their choice in the majority of instances. Sufficient effort could be exerted to commission them in their proper rank and data could be compiled upon their capabilities and most efficient usage in time of war so that calling them up and ordering them to duty would be largely routine. Such a program is a complete departure, of course, from the traditional past when physicians volunteered their services as a part of their civic duty, but in view of the competitive spirit of the majority of civilians, including physicians, this appears to be a practical attitude for the responsible authorities to take. Set the goals to be met, give them a reasonable chance to meet them but be prepared to meet them with Selective Service if necessary. A physician has the same obligations toward national welfare as any other citizen." *****

RECORDER

RESTRICTED

L. K. Pehl

34

L. K. Pehl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain O. B. Morrison, Jr., MC, USN
dated 23 April 1948)

***** "a. Classification and mobilization of medical manpower
for the armed forces.

A frequent complaint during the early mobilization period was that medical officers who had been in the inactive medical corps reserve had stagnated in the junior ranks for years and were called to active service as Lieutenant (jg) or Lieutenant, while doctors who had never been members of the naval service were offered commissions on the basis of age, irregardless of professional training or experience.

It is believed that medical groups should be organized into reserve units in accordance with the anticipated war-time needs of the Navy in time of war. These reserve units must be convinced that the active Navy supports them and is interested in their welfare and training. The majority of doctors are primarily interested in a specialty, and plans should be made to utilize medical officers in their chosen specialty when it is necessary to assign them to active duty." *****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Arthur B. Welsh, MC, USA
dated 19 April 1948)

***** "a. The Army scheme of classification of doctors was not generally applied and got under way too late. There were too many 'classifiers' and too few qualified personnel classification officers. The system wasn't well understood. The Army Medical Department Classification System as established could have been employed profitably to qualitatively express the available resources and would have assisted in quantitatively and qualitatively showing the requirements of the Armed Forces and using civilian agencies. In my opinion there was no long range Nation-wide plan for the mobilization of medical manpower. The strategic concept of the war and high level policies, when developed, didn't filter down to medical planning agencies. There was no all out mobilization plan. Selective Service didn't assist materially in obtaining doctors. The plan formulated by the Preparedness Committee of the AMA, approved by the War Department in late 1941, and operated under the Federal Security Administration as the Procurement and Assignment Service turned out surprisingly well. There was discrimination so doctors say. It would have worked to perfection had there been better classification earlier; had authority to force a physician to accept service existed; and had the armed services and civilian agencies conceived and effected an integrated plan of medical service supported by phased quantitative and qualitative requirements for an all out effort. A medical monitor at topside would have insured medical economy and operating efficiency. There was too much decentralized control. That so necessary centralized control at highest command level was lacking." *****

RECORDED

RESTRICTED

L. K. Pehl

L. K. Pehl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter , Colonel F. A. Blease, MC, USA dated 19 April 1948)

"1. Classification and mobilization of medical manpower for the Armed Forces.

"a. During World War II, about 60,000 of the 160,000 practicing physicians in the U. S. saw service with the Armed Forces. In any war of the future, it can be assumed that casualties among civilians will probably increase the civilian requirement for medical service. Careful consideration must be given to civilian medical requirements and since the supply is limited, efficient utilization is essential.

"b. Separate procurement of doctors by Army, Navy and Air Corps proved to be wasteful and unsatisfactory. Competitive bargaining and hoarding resulted, the service had an abundance of a particular type of specialist and others had a shortage. It is more important that this be corrected by a system of centralized control government procurement, classification and distribution.

"c. In the recent war, many of the doctors who remained in their civilian communities took over the work of one or more other doctors who entered the Armed Forces. These civilian doctors worked under considerable stress, and needed more physical stamina than many of their colleagues who were in military service. In any future mobilization, consideration must be given to the physical quality, as well as to the numbers of doctors who are delegated to care for the civilian population. Early in the mobilization, some doctors who possess physical defects should be inducted into the Armed Forces. There is professional and staff work that many of them can perform. Even the aged doctors - those too old to carry on civilian practice or serve in active military units, can be used in physical examinations, laboratories, and similar places where physical endurance is not required. This would save their able-bodied colleagues for the severe demands of civilian practice.

"d. Doctors serving at induction stations should be given more instruction concerning military requirements, the man-power problem and classification of defects. Too many men were lost to the service because of physical defects. Except for those unable to function in civil life, none should be flatly rejected (4F). As the demand for man-power for the military service becomes increasingly urgent, these defectives must be used and fitted into the service according to their capabilities. The morale and prestige of men who have been rejected is seriously affected in a community and should be considered. On the other hand, there was considerable criticism of the system which rejected well known athletes etc. who continued to indulge in strenuous sports in civil life after being classified for military service as unfit. The impression that all men must be fit for actual combat duty is harmful and must be corrected."

RECORDED

L. K. Pehl

L. K. Pehl, Colonel, MC

37

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Dr. Howard A. Rusk dated 22 April 1948)

***** "I also feel there is a great need for a civilian medical board as a functioning agency of the National Securities Resources Board to establish national policies and programs for the distribution of medical manpower and facilities to the civilian population, industry, agriculture and the armed forces in time of national emergency." *****

TRUE COPY EXTRACT (Letter, Dr. Howard A. Rusk to Secretary for Air dated 27 January 1948)

***** "I appreciate your attitude that the broad over-all service planning must come first and this should be carefully coordinated with the civilian needs and problems. I think it is generally recognized that there must be a coordinated overall medical service, that many of the medical needs are common to all services and also many are specific to each.

"With these facts as a basis it is my personal conclusion that the problem could best be met by the establishment by directive of the Secretary of Defense under Public Law 253, a medical coordinating board composed of the Surgeon General of the Army, Surgeon General of the Navy, the Air Surgeon and such other medical personnel as might be selected by the Secretary of Defense. The purpose of this board would be to assure full utilization of all available medical personnel, medical specialist and hospital facilities, to develop plans for adequate and efficient medical support of task forces, to standardize administrative procedures common to each of the three services and to coordinate with federal, state and civilian medical and associated agencies. This would, in effect, be a continuation of the Hawley board as a permanent board." *****

REC-117

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

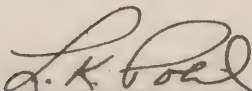
38

RESTRICTED

TRUE COPY EXTRACT (Letter, Dr. Martin Karr - dated 3 April 1948)

"I, like many other medical officers, watched with sadness the way in which the Army wasted manpower. I particularly watched the waste of medical men. I realize too well that there are no economical wars, both from the point of view of dollars and manpower. However, everybody sees a war from his own perspective. It was disheartening to hear the criticisms of my friends at home of the lack of medical manpower when I knew that so many medical officers sat idly all over the world.

"I do not pretend to be a specialist in army strategy. One little suggestion has been in my mind for some time and now I have taken the courage to write it down. It would be my suggestion that the Army and the Navy and the Marine Corps draft all of the men that they need, but in the case of medical and other essential professional skills, could it not be possible that a small percentage of this group be drafted but be permitted to stay home on a military status and be ready to move on 24 or 48 hours notice if the emergency became acute. I realize that men must be indoctrinated and I realize too well that we cannot be civilians and military at the same time, but, if we can consider this as an alerted group, who will not get themselves involved in any financial transactions, houses, etc., but go on practicing in their various communities on a day by day basis until they are called or stay home if they are not called. This will enable the community to still have adequate medical manpower and at the same time, it will permit the Army to have a reserve to call on if the emergency became grave."



L. K. Pohl, Colonel, MC

RESTRICTED

RECORDER

RESTRICTED

TRUE EXTRACT COPY (Letter, Rear Admiral C. B. Camerer (MC), U.S.N.,
Retired dated 21 April 1948)

**** "In order to obviate infiltration of "misfits" throughout
the Medical Services, the following is suggested:

1. Careful screening re
 - a. Age
 - b. Health
 - c. Professional qualifications and background.
 - d. Racial and social affiliations.
2. Assignment of younger men in excellent health for active duty in combat areas re
 - a. Afloat
 - b. Air activities
 - c. Advanced bases
 - d. Marine expeditions, etc.
3. Men of more mature years, etc., for
 - a. Training Centers
 - b. Hospitals, dispensaries, clinics in home areas
 - c. Blood banks, etc.
4. Rehabilitated casualties to be assigned only to such duty as their physical and mental condition warrants.
5. The prompt reversion or dismissal of all Reserve Medical Officers to an inactive status who have clearly demonstrated their unfitness for service with the Armed Forces, regardless of cause or excuse. (There are unfortunately many such individuals.)" * * * *

L.K. Pohl

L.K. POHL, Colonel, MC

RESTRICTED

RECORDED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain H. D. Templeton, MC, USN
dated 23 April 1948)

**"(A) CLASSIFICATION AND MOBILIZATION OF MEDICAL MANPOWER FOR THE
ARMED FORCES.**

This very important subject has received much consideration; as early as 1936-37, the Bureau of Medicine and Surgery authorized the organization of several medical specialist units in various cities throughout the country, preferably those adjacent to a medical center. The complement of those units was 12-14 medical officers, and each member a well recognized specialist in his particular field of medicine or surgery. Such units were inactive volunteer reserve organizations, headed by a senior surgeon or a senior internist, whose duty it was to organize the unit, convene monthly meetings, and keep the District Medical Officer advised of its training.

Apparently the Bureau's plan for the mobilization of such volunteer organizations as complete units did not materialize. In 1940-41, when our entrance into the last war became more and more imminent, various members of those volunteer units reported for duty at our hospitals. Several were quite disappointed and disillusioned in that they had been separated from their organization, and in so doing, they felt they had lost their identity as specialists. I feel sure, however, in a great percentage of instances, misassignments were corrected, but only after each individual proved his special professional talents and capabilities.

The above noted procedure was no doubt the best plan devised at that time to effectively organize, classify, and train reserve medical manpower for the armed forces. And, had it been more vigorously pursued, it is reasonable to assume that a fair amount of classification and preliminary indoctrination would have been accomplished prior to the beginning of hostilities.

In September of 1947, the Bureau of Naval Personnel, through its Naval Reserve Letter No. 36-47, authorized the organization of volunteer reserve components of the medical corps of the Navy. This general plan for the organization of some 240 volunteer medical divisions is not thorough and complete, and it seems to many of us that it is the most practical method devised for the organization, classification, training, and mobilization of medical manpower in the event of a national emergency.

At the present time, there has been much discussion and debate relative to the feasibility of re-establishing selective service and universal military training. Many of our most reliable political and military leaders, as well as a goodly number of educators have questioned

RESTRICTED

RESTRICTED

the benefits derived from short term basic military training and indoctrination, and have reinforced their arguments with many convincing reasons for not reestablishing this type of training. As far as the training and effective indoctrination of medical manpower is concerned, I feel that we could accomplish far more by assisting materially in the organization of the 240 medical divisions as outlined in the above-referenced plan. Training performed in such organizations could well supplant that of the training stations, and more effective indoctrination of medical personnel in specialized duties might be accomplished.

I feel that it is necessary that the proposed 240 divisions be given financial support and administrative assistance, plus individual remuneration comparable to the training pay received by active reserve units. It is also quite necessary that armory facilities be provided where such divisions could meet at regular intervals and conduct a well organized training schedule that would accomplish the purpose for which such divisions are designed. I feel reasonably certain that this assistance is necessary, because very few doctors and nurses and specially trained personnel will give their time and services without a nominal remuneration. The commanding officers of such medical divisions require a minimal amount of clerical assistance in order to effectively organize and maintain their complement up to strength at all times. I feel that anything short of this will not assure the results desired by the Bureau; the volunteer medical division without such aid will amount to little more than a roster of the names of certain doctors, nurses, and enlisted ratings who agree verbally to serve as a unit in the event of another national emergency. Certainly such is not the intent and purpose of the plan, because conscription would accomplish this end equally as well.

This plan, in my opinion, serves two major purposes of equal value and importance; it assures organized, classified, and partially trained medical manpower that may be quickly mobilized, and it provides a more desirable substitute for universal military training and selective service, which will continue to be vigorously opposed by political factions and various other influential organizations.*****

RECORDED

RESTRICTED

42

L. K. Pohl

K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel O. F. McIlroy, MC, Air Force
dated 20 April 1948)

***** "a. Preparation for mobilization of medical manpower for the Armed Forces should be accomplished during peacetime and should be kept current just as in the case of industrial mobilization. Participation in national defense should not be left to the whim of an individual and should not be dependent upon voluntary membership in any reserve or National Guard organizations. Knowing the total number of medical personnel required by the services in various military situations and also knowing the total number of such personnel within the United States, a decision should be made as to the numbers that should be taken from various localities, thus attempting to leave those localities with an equitable medical coverage. Those scheduled to join the Armed Forces in case of an emergency should be so informed, and so long as they remain on the mobilization list, they should be required to undergo a brief annual physical examination, and they should submit an annual report, indicating their training, retraining, experience, and interest in the various fields of medical practice. During any emergency, the portion of this medical personnel actually taken from any locality should be dependent upon the military situation and priority of call should be previously established. This system would establish the basis for classification, as well as a plan for mobilization. A great portion of the functioning of this plan should be made a matter of civilian responsibility." *****

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Robert M. Gillett, (MC) USN
dated 15 April 1948)

" The prewar, or the present medical reserve organization, does not appeal to me as the proper method for speedy or adequate mobilization of the medical department. The establishment, by District Medical or the Corps Area Officers, of an active file on every Doctor in the district -- cross indexed as to age groups, professional qualifications, military training, availability, etc., would serve the purpose much better; as undoubtedly any future war will necessitate the use of the draft system to a great extent." *****

L. K. Pohl

L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Dr. A. R. Shands, Jr. dated 20 April 1948)

***** "The classification and mobilization of medical manpower appeared satisfactory. A great many of the specialists were not assigned to work in their capacity in the beginning because of faulty classification. However, this was the exception rather than the rule." *****

L. K. Pohl

L. K. Pohl, Colonel, MC

RECORDER

RESTRICTED

RESTRICTEDTRUE COPY EXTRACT (Letter, Captain Lewis T. Dorgan (MC) USN)"Classification and mobilization of medical manpower for the Armed Forces.

"Entirely too many physicians were declared essential by a local board regardless of their physical condition and fitness for active military duty. On the other hand, many men motivated by patriotism were accepted for active duty regardless of various physical handicaps. Many of the latter broke down under sea and field conditions when their services were most urgently needed and at a time when replacements were difficult to find.

"The doctors who did not enter service held lucrative practices and bettered their financial condition unreasonably while their colleagues in the Armed Forces sacrificed equipment, practice, and savings to serve.

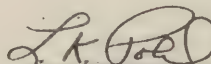
"Suggested Remedies:

"(1) That all physicians be conscripted into the Armed Services; those who are in the younger age groups, and physically fit, to be assigned to sea and field duty while the physically handicapped and aged, man the continental activities and care for the civilian.

"(2) That all physicians under the age of 45 years be inducted into a reserve Medical organization and that they be indoctrinated in a basic course of military medicine.

"(3) That all physicians over the age of 45 years be assigned to a 'home guard' subject to the same military control as the younger age group. These men should have extensive training in atomic radiation protection and general first aid and emergency surgery procedures.

"(4) That all reserve medical officers be trained to serve as independent medical officers and that no stress be laid on specialist units. These units were clannish and in many instances offered serious passive resistance to the senior administrators of the regular corps."



L. K. Pohl, Colonel, MC

RECEIVED

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

**** "a. Classification and Mobilization of Medical Manpower for the Armed Forces. It is my belief that all medical and dental practitioners throughout the U. S. should be classified as to their specialty, if any. Classification should be based upon: (1) Their demonstrated ability before the various professional boards, (2) Their reputation as known in their County and State Societies, and (3) Their age and years of experience. Classification could best be accomplished by the American Medical Association federally sponsored through a committee appointed by the Secretary of Defense. The mobilization of medical manpower should be based upon the minimum needs of each community, considered with the minimum requirements of the Armed Forces, i.e. City, County, and State, and no volunteers accepted from any community after the minimum number or community requirements is reached. Mobilization should start with volunteers, but selection should be carried out to fill the needs of the service after volunteers are accepted." ****

TRUE COPY EXTRACT (Letter, Colonel Harvey B. Porter, MC, USAF
dated 23 April 1948)

***** "a. Classification of medical man-power! The human attributes were untouched upon. The lower age group, lower classified officers performed better in the field and presented far less of a morale problem than did the specialists." *****

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY (Extracts from Ltr Col. Harry G. Armstrong, MC, 16 April 1948)

**** "a. Classification and Mobilization of Medical Manpower for the Armed Forces.

(1) Defects:

- (a) Reserve officers called in at their rank, while civilian components often given initial higher rank.
- (b) Trained Medical Department specialists (enlisted) assigned to combat units because of being physically fit.
- (c) Classification system not established early enough.
- (d) Specialists called to duty before actual assignment available for them.
- (e) Ill-trained medical officers accepted for military service early in emergency, giving wrong impression of caliber of medical care.
- (f) Uncoordinated staff planning between Medical Department, line and other service branches.
- (g) Dental conditions existing in draftees on induction made adequate dental care impossible during service.

(2) Remedies:

- (a) Early classification and periodic review of all potential medical officers—preferably through county medical society under War Department guidance.
- (b) Utilization of specialists in general hospitals or centers only, (except where specialty needed on front line).
- (c) Retention at all times of personnel trained for medical service.
- (d) Full use of limited service personnel under the provisions of MR 1-9.
- (e) Exploitation of female manpower for Medical Department service.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT

(Letter from Rear Admiral A. H. Dearing (MC), U. S. Navy
dated 26 April 1948)

**** "(a) Classification and mobilization of medical manpower for the
Armed Forces.

Prior to Pearl Harbor day a great many Reserve medical officers had been formed into "Specialists Units" consisting of highly trained specialists, ostensibly for the purpose of manning a hospital or composed of medical officers with particular skills and with a specialty such as; surgical teams, neuro-surgical groups, etc. These officers were recruited for the Naval Reserve with the idea that they would be utilized in their specialty and as teams. However, very few of these teams were utilized and in many cases the teams were broken up, the units were dispersed and medical officers were assigned to duties which had no relation whatsoever to their training as specialists in civilian life. This has been a subject of considerable bitter comment on the part of Reserve officers and has been quoted as a reason for their lack of confidence in any medical plan in the part of the Medical Corps of the Navy.

With regard to classification of specialists, the writer observed a number of medical officers who were classified as specialists. When they were placed in duties which a specialist should be able to perform, these officers were totally unable to perform these duties. In short, it would appear that the premises on which they were classified as specialists were entirely inadequate. To the knowledge of the writer there is no standard set up at the present time to determine which officers of the Naval Reserve shall be qualified as specialists in a particular branch of the medical profession. The BuPers Manual in paragraph E-1206, page five, states that MOS, USNR will consist of medical officers in the following categories:- "Those whose training is so highly specialized that they do not qualify for general duty; (who will determine this and by what standards) those whose age is 50 years or over; and those not physically qualified for unlimited duties". It would appear incongruous that the designation of (S) which all Reserve officers have been given to believe applies to specialists should also apply to officers over fifty and to officers unable to do sea duty.

With regard to mobilization of medical officers it was noted that immediately after Pearl Harbor hundreds of medical reserve officers were ordered to Naval Hospitals merely for the purpose of getting them on active duty for indoctrination and then within a week or ten days were ordered to some other duty. This use of a Naval Hospital as a Receiving Ship for medical officers at a time when the hospitals are at their busiest because of the increased load of admissions, appears to be a mistake. There is no time for the permanent staff of the hospital to indoctrinate medical officers when they are busy with their clinical duties. It is believed that it would be of benefit to have some central point within each Naval district for the mobilization of medical officers rather than harassing the workings of a Naval Hospital with these supernumeraries at the time of mobilization." ****

RESTRICTED

L. K. Pohl
L. K. Pohl, Colonel, MC

49

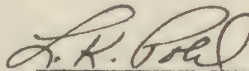
RECORDER

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. R. Urban (MC) USN
dated 28 April 1948)

***** "(a) Classification and mobilization of medical manpower
for the Armed Forces.

"(1) In the mobilization of medical manpower, consideration
should be given to those who prefer administrative duties and those
that prefer purely professional duties. There were many in the last
war whose talents were entirely lost to the service." *****



L. K. Pohl, Colonel, MC

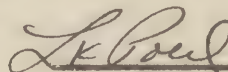
TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee dated 18 April 1948)

"There was unquestionably widespread dissatisfaction and criticism of the
military medical services during the past war on the part of medical officers.
There is an apparent disinclination on the part of well qualified young doctors
toward entering military service. There will be even greater unfavorable re-
action in a future emergency if no remedial steps are taken. The opportunity
to comment on these matters is welcomed.

"Reference is made to Paragraph 3 of letter dated April 8. Comment is
made on the subjects as listed.

"(a) Classification and mobilization of medical manpower for the Armed
Forces.

"In times of peace, now, as soon as possible, every single active doctor
in the country should be classified and catalogued for possible military or
civilian service in times of war. It should be recognized that civilian defense
is equally important with military medicine, and service therein no less praise-
worthy. Every doctor without exception should have a role assigned to him and
a number indicating his liability to call. This should be done through the
American Medical Association and County Medical Societies under legislation by
Congress. The physical standards for medical officers in the Army, and parti-
cularly in the Navy, were absurdly high and these should be modified in accord-
ance with a common sense appraisal of what a medical officer's duties are likely
to be rather than on the apparent assumption he was to march 30 miles a day
with a pack on his back." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RECORDER

RESTRICTED

TRUE COPY (Extract Ltr Nellie Jane DeWitt, Captain (MC) USN, 29 April 1948)

***** (a) It is the opinion of this office that greater responsibility should be given to each District Medical Officer in connection with the procurement, assignment and distribution of nurses.

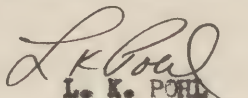
PROCUREMENT

Wider and more effective publicity should be given to the procurement of nurses for the Navy. We suggest -

- (a) That an officer especially trained in public relations duty (other than a nurse or a doctor) be assigned to the nurse corps procurement program in the various Districts.
- (b) A Navy Nurse selected because of her special fitness for such duty should be assigned so as to be available for public appearances in connection with procurement programs, as well as to interview candidates.

All nurses under the age of 45 years, married or single, should be members of the organized Reserve--Army, Navy, or Red Cross. Membership lists should be available to the District Medical Officer in each District.

All candidates for commission in the Nurse Corps should be commissioned as Reserves. This method would shorten the period between application and appointment, and would provide an opportunity to observe the candidate before giving her status in the Regular Nurse Corps.*****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr Alfred W. Eyer, Captain (MC), USN, 17 April 1944)

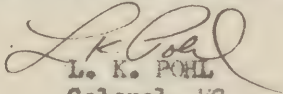
**** "(a) Classification and Mobilization of medical manpower for the Armed Forces.

"It is suggested that a study be made of available members of the medical profession in their current locations, listing their ages and qualifications. Further, that continental United States be divided in to "professional areas" and medical facilities plus medical talent be "pinpointed" within their respective areas.

"In the event of total mobilization of manpower and resources, this should permit an equable distribution of medical talent to the Armed Forces and the necessary civilian requirements. It will provide, additionally, a broad picture of facilities available and utilizable in emergency situations.

"Suggest a special clause in the Draft Law or Universal Military Training, if adopted, that will include graduating medical students and young men of the medical profession who have had little or no contact with the Armed Forces.

"In anticipated total mobilization, it would be of considerable value to both Armed Forces and civilian professional medical men to have a "meeting of the minds" regarding true national objectives. This is considered highly important; in order to insure good cooperative functioning between the Armed Forces medical personnel and their civilian counterparts in the defense organization. It is my impression that, heretofore, professional men of the Armed Services and the great mass of civilian doctors have gone their respective ways entirely oblivious of their dual responsibilities in connection with the overall national welfare." ****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel James H. Forsee, M.C.
dated 20 April 1948)

**** "(A) Classification and Mobilization of Medical Manpower for the
Armed Forces.

1. The policy employed of having local and national medical organization determine which members of the profession are available for duty with the Armed Forces seemed to have been feasible and practical. It certainly decreased the opportunity for criticism leveled at the Armed Forces in respect to determining which members of the profession should be in military service and which should remain in private practice. The inauguration of this policy on a much wider scale as a preparatory peace time measure is suggested. A civilian medical organization, probably the American Medical Association, could render a very valuable immediate service to the military establishment and each physician could be properly catalogued as to professional capabilities and eligibility for military service. This listing should be kept current and close coordination with the Medical Department of the Armed Forces should be maintained. The individuals concerned should be kept informed as to their classifications and be given a tentative mobilization assignment. The importance of keeping such an assignment current is evident.
2. It would seem feasible to contemplate total mobilization of medical manpower. In such an event it is imperative that a cataloging of doctors, dentists, etc. should be considered an urgent requirement. Dispersion of this information relative to cataloging of individuals is necessary and should not be centralized in one office.
3. For many years it has been recognized that certain deficient qualifications existed in many of former officers of the Medical Administrative Corps. This is probably going to be corrected by the organization of the Medical Service Corps now in operation. The possibility of commissioning officer personnel, Second Lieutenants of the line, in the administrative section of the present Medical Service Corps positions might well be investigated.
4. Medical Schools and Teaching Hospitals. During this post-war period careful thought may well be given to the establishment of important courses of instruction in Medical Schools to acquaint the undergraduate student with the problems of War Medicine, Surgery, Preventive Medicine, etc.

RESTRICTED

RESTRICTED

These courses could in many instances be included in the already established medical curriculum. For example, courses in surgery, might devote time to the presentation of the principles concerned in the management of war wounds. The department of medicine could emphasize malaria as a major military problem. Neuropsychiatry easily lifts itself to a discussion of the problems made manifest by war.

The present ROTC plan in Medical Schools is excellent but does not go far enough. At the moment such facilities are materially aiding in the professional training of Regular Army Medical Officers. It is suggested that when sufficient qualified specialists are available in the regular military establishments that the assignment of such personnel to positions in medical schools as coordinator of medical military activities and professor of Military Science and Tactics in that institution might be advisable. In a protracted war, adequate means for continuing teaching in medical schools and teaching hospitals is fundamental. In the recent war much criticism was leveled at the War Department for what was believed to be an unnecessary and rather arbitrary method of interfering and interrupting medical school teaching and hospital training. Whether or not this was a justifiable criticism the fact was evident that for much of the war period the military forces had many more doctors than actually needed. Under conditions of heavy battle, it had been my experience, that it is almost impossible to always have enough doctors at the locations most needing their services. The Armed Forces during the period of War is not the place to carry on post-graduate teaching and other institutions must be properly staffed to carry on this function of furnishing the military services with qualified surgeons, internists, etc. The older members of the medical school faculty should and must meet the responsibility of teaching. The younger men, with or without comparatively minor disabilities must be permitted to share in the more hazardous military assignments. In view of these suggestions the following recommendation is submitted:

The establishment of professorships in military surgery, medicine, preventive medicine, etc. in several leading medical schools. The Federal Government would under this plan sponsor the professorship and contribute financially to their support either in whole or in part. The additional pay of, say \$5,000 annually to an already established full professorship in surgery at John Hopkins University, Columbia University, University of California, or other medical schools would make these positions definitely more attractive. The Armed Forces should be consulted and would naturally advise in the appointment of individuals in such positions. This plan would in no way interfere with our present plan of residency training in

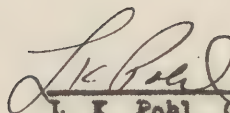
RESTRICTED

RESTRICTED

civilian institutions, but rather it would enhance its importance and more closely coordinate the civilian and military medical profession.

5. Enlisted personnel.

The abandonment of the Enlisted Men's Technicians Schools established during the War was, it is believed, ill advised. It is highly desirable that at least a 6 months period of basic military training and instruction in elementary technical medical problems should be required of all medical enlisted personnel, male and female." *****



L. K. Pohl, Colonel, MC

RECORDED

RESTRICTED

RESTRICTED

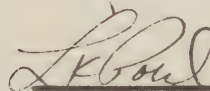
TRUE COPY EXTRACT - (Letter, Brig. Gen. P. J. Carroll, MC, USA, Retired
dated 19 April 1948)

*****7. It is a well known fact that a complete reorganization of the medical services in the United States is urgently needed if we are to properly meet our obligations, military and civilian, in the event of another war. Our next war will be fought in the air, on and under the water, on land, in the tropics and the arctic, on the American and other continents. We must be prepared to make full use of the services of all physicians and dentists with a minimum loss of time and motion."

TRUE COPY EXTRACT (Letter, Colonel John A. Rogers, MC, USA (Ret.)
dated 19 April 1948)

***** "A. Classification and mobilization of medical manpower for the Armed Forces.

"It seems to me that this was conducted fairly efficiently for World War II with the possible exception of the mobilization of physicians too rapidly, thereby crippling civilian communities prematurely. In some instances the mobilization of affiliated units seriously crippled the staffs of hospitals. I believe this should be carefully studied since there are many factors such as the training of enlisted personnel and nurses to form an integrated unit. Many factors are involved, of course, but it is believed improvements could be made." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel R. E. Stone, MC (Res.) Air Force
dated 22 April 1948)

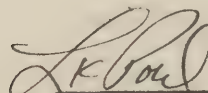
***** "(a) Classification and mobilization of medical manpower for the Armed Forces.

"It is my belief that no physician or dentist should be taken into the Armed Forces with a rank less than Captain. This would in a way compensate these people for the years of training and the personal sacrifice they make in giving up an established Medical Practice which disappears rapidly after they are no longer there to look after it. Commensurate higher grades to be given to those men with special qualifications and training." *****

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus (MC) USN
dated 27 April 1948)

***** "(a) A system of 'Classification' of medical manpower is considered essential not only in meeting mobilization of the Armed Forces needs but also to provide medical care for the civil population. If mobilization plans for medical personnel provide for the organization of medical specialist groups within the Military Reserve to serve as coordinated nucleus units in major military hospital activities it is believed that every effort should be made to keep them intact when called to active duty. They will then function to best advantage and in every way render a greater service to the Services. Although the exigencies of the Military Service require the performance of many tasks foreign to civilian practice it is considered important that in so far as possible all medical personnel especially trained in any given line should be assigned duty where full advantage can be taken of their individual talents. We have all seen too many square pegs in round holes." *****

RESTRICTED




L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY (Extract Ltr M.C. Stayer, Major General, U.S. Army ^ARetired, 19 Apr 48)

***** (a) Classification and mobilization of medical manpower for the Armed Forces.

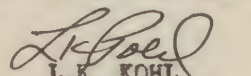
Unfortunately, I was not in the United States during the war period. However, I believe the classification of individuals and mobilization of medical manpower was done as well as could be expected." *****


L.K. POHL
Colonel, MC

TRUE EXTRACT COPY (Letter, Col. Robert P. Williams, MC, Surgeon, 16 Apr 48)

***** (a) Classification and mobilization of medical manpower for the Armed Forces.

I advocate a universal draft - all males of military age to be called up and assigned to civil or military duties. All doctors designated for military service to be classified as to MOS and given a priority for call to active duty; for instance, junior officers of scarce categories, such as physical medicine and plastic surgery, should expect to be called early. Highly specialized doctors to be called just before their unit starts actually functioning, either in the U.S. or overseas. Administrative and training officers would be called early to organize the unit and start its training; those on professional duty would be called early to organize the unit and start its training; those on professional duty would be called just in time to get minimal training before they start caring for patients. In the last war there was active competition between the various services which resulted in over-supply in one place, shortage in another. Unification should obviate this. Personnel procurement should be national for all Armed Forces." *****


L.K. KOHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr James E. Hix, Lt Col., MC, (Resigned) 11 April 1948)

*****Sufficient experience was gained in the last war that I would think a satisfactory scheme of classification could be evolved in time of peace—and then the doctors mobilized according to need. I visualize total mobilization for the next one. Government take over everything. The doctor who stays at home makes exactly the same as his classification allows his military brother. The rest is taxed. The G. I. Joe makes the same as aircraft worker brother. The classifying should be done by the AMA for best cooperation. If not a specialist, years of experience would qualify for a certain rank—regardless of the T/O. I'm afraid that I favor the rather radical total mobilization idea which would then leave the military with no problem."*****

L. K. Pohl
L. K. POHL
Colonel, MC

TRUE EXTRACT COPY (Ltr. Brig. Gen Guy B. Denit, MC, Surgeon, dated 13 April 1948)

*****Classification and mobilization of medical manpower for the Armed Forces. This can be accomplished only after a complete estimate of the medical situation. By that it is meant the total requirements for the civil population and the Armed Forces must be measured against the total medical talent available. Carefully worked out requirement tables for each armed service, not only as to numbers but as to special qualifications, must be prepared well in advance of mobilization. The allocation of this talent must be on a level higher than the Joint Chiefs of Staff. The proper place for this is in the National Security Resources Board. It is essential that the American Medical Association have complete information as to professional qualifications and talents of each and every doctor in the country in order that an equitable distribution of talents may be made to the three services. There should be and must be an interchange of doctors between the services in accordance with the requirements as developed by the type of warfare to be conducted. This is a subject which requires a great deal of careful study by medico-military planners and the various committees of the American Medical Association." *****

L. K. Pohl
L. K. POHL
Colonel, MC

RECORDED

RESTRICTED

RESTRICTED

BRUE COPY EXTRACT

(Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 22 April 1948)

***** (a) Medical Manpower -- It is my belief that possibly you will have to draft medical manpower and I assume that your priorities would well be first those ASTP men who have not served but have received some educational training as the result of the ASTP. Secondly, I would assume that you would include those physicians who had not had service in this last war. Third, I would hope that you would include those who had had less than a years service. Lastly, I would assume you would take those individuals who were in the service previously. Except for those reserve officers who wish to volunteer I would presume it would be wiser not to call on them. I believe that this will not however account for the specialists needed in the higher categories which in the army we called Class A and Class B specialists. Undoubtedly you will have to make some special provision and I assume that the Services will be figuring out the number of these individuals depending on the strength of the various Services, the number they will need. Whether these persons can be approached individually or not is a matter which I think has to be given consideration but assume that is the only way you could get them.

It is my strong conviction that all officers, and particularly medical officers should be given training in the area of mental hygiene and preventive psychiatry. I think they have to be taught because of our failure in medical education to recognize the need of treatment for emotional disturbances at all levels: Officers Candidates Schools, Boot Camp, Basic Training Camp, etc. When we face the cold fact that we lost nearly 50% of all separations from both army and navy because of personality problems, it seems to me fundamental that we expect all officers both line and particularly medical to recognize the nature of this type of loss of manpower and what can be done about it.

It is my further conviction that medical officers should be procured only at the rate for which there is an actual need with due regard to their assignment in accordance with their specialty training and experience. In the last war many were inducted six to twelve months in advance of any real need for them and placed in pools until they were finally reassigned in relative conformity with actual military needs. This was very expensive and very bad for morale and engendered what we all recognized as a kind of "browned off" state of many of our civilian physicians who were in the Service, currently manifested by many of our doctors.*****

RESTRICTED

L. K. Pehl

L. K. Pehl, Colonel, MG

RESTRICTED

TRUE COPY (Extract Ltr Albert T. Walker, Captain, MC, USN, 26 April 1948)

**** "During a national emergency, financial remuneration for such select groups as doctors, nurses, and various technicians should be equitably distributed in each group so that individuals would not benefit financially from the service rendered by others. We should go back into the medical schools and require every man accepted for medical training to take some work in radiological safety, epidemiological disease control, casualty handling, and basic medical officer training, so that these subjects will not be completely unfamiliar when and if called to render service to his country. He should also be required to indicate preference for the branch of service or civilian billet he desires and so carried on a master roll with up-to-date information kept on him in the Joint Medical Staff office during his medical school career and after graduation. Mobilization of Armed Forces and civilian medical offices would then be within workable limits when the need arises for such a step. Again it should be emphasized that this program must be coordinated at Cabinet level."****

L. K. Pohl
L. K. POHL
Colonel, MC

RECORDER

TRUE EXTRACT COPY (Ltr Capt. E.P. Funkel, MC, USN, dtd 21 Apr 48)

***** A. "In times of national emergency, the medical corps of the armed services should be brought immediately to full strength by voluntary application, if possible, if not possible, then medical officers should be drafted."*****

L. K. Pohl
L. K. POHL
Colonel, MC

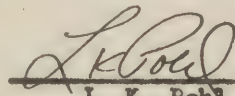
RECORDER

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Letter from Colonel Richard T. Arnest, Ret.
dated 19 April 48)

*** "a. I am not in a position to fully answer this question, however, I have always been of the impression that medical enlisted personnel for the army were poorly selected and inadequately trained. A well trained and proper selected enlisted medical corps in time of peace would go a long way toward quickly training the expanded corps in time of war. Officers and nurses on the other hand spent entirely too much time in training camps during World War II. I would recommend that at least two Medical Department Training Stations be maintained in the United States during peace, one in the south east and one in the west. All medical enlisted personnel would be given at least three months training in one of these camps prior to assignment to duty. " *****

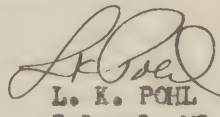


L. K. Pohl
Colonel, U. S. Army

TRUE EXTRACT COPY (Ltr fr N. C. Mashburn, Colonel, MC, AF, 19 April 1948)

*****"A classification of civilian-medical personnel by a system similar to the one now used in the service would be of great help in time of mobilization.

Recommend a plan to subsidize medical education for personnel of the Armed Forces be developed."*****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M. J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

***** (a) Classification and mobilization of medical manpower for the
Armed Forces.

Despite many difficulties and duplications of effort, some degree of criticism and perhaps a degree of confusion, I believe that those charged with the mobilization and classification of our medical manpower performed their tasks efficiently and well. The services were, however, engaged in competitive recruiting. This had its undesirable and untoward effects. The competitive bidding defeated the standardization and resulted I think in certain basic inequalities of rank, assignment, and opportunity. In any future National emergency in which the several services engage as a more definitely merged armed force, a central personnel agency could function to the best possible advantage in the assignment and deployment of medical personnel. However, if the union of the services is to allow each service freedom of action in its procurement and mobilization functions, then I see much merit in the plans and measures that are now in force. I refer particularly to the creation of medical divisions which are set up in our naval districts. These to my mind represent a marked improvement over the medical specialists units which served so well during the past war. The medical specialists units by reason of their small size and the limited number of personnel which comprised them could be used to best advantage in duty assignments wherein they more or less completely staffed the activity, so for example they were utilized in hospital ship duty to the best possible advantage. Equally important and practicable perhaps was their use in certain shore activities where again they more or less completely staffed the facility. In some instances where two or more of these units served together matters did not always proceed smoothly. Personal relationships at times became stalled, professional inequalities were unduly emphasized, and jealousies were sometimes developed to an unwarranted degree. This was particularly true when the medical personnel were not fully occupied by professional work. When they became so occupied the clashes and differences rapidly disappeared. Indeed, as can be well understood, I never came in contact with a busy actively engaged medical unit which failed to exhibit a high degree of morale.

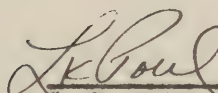
It might be expected that a future war will see visited upon our civilian population more of the death and destruction which has hitherto been reserved for our uniformed personnel in conflict. Perhaps our own land will not be spared in a war of the future. Casualties among civilians may be heavy. If this is a possibility then due regard must be paid to the medical needs of our civilian population. They must not be recklessly stripped of their doctors nor should they be expected to furnish an undue proportion of the able-bodied and more active members of the medical profession.

RESTRICTED

RESTRICTED

The army and navy need for the most part, young able-bodied medical officers particularly in those duty assignments which require prolonged and exhaustive efforts; however, we shall continue to need also a fair leavening of the older and more mature groups; so it would seem that what we should strive for is the procurement and operation of a well-balanced group. Whenever and wherever possible, rank and duty assignments should conform to the qualifications of the individual.

If a single agency for the procurement of medical officers is to be set up in the future, I believe it should be operated and controlled by officers of the service rather than by civilians. The services of civilian doctors as aids and consultants can be employed according to need." -----



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Col. Robert K. Simpson, USA (Ret.)
dated 1 May 1948)

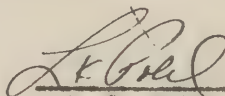
***** "(a) Classification and mobilization of medical manpower for the Armed Forces. It is my opinion that military medicine should be compulsory in all recognized medical, dental and nursing schools, and graduates of such schools automatically commissioned in the Reserve, even tho physical qualifications may restrict activity to limited service. If some form of military training be adopted, high school and undergraduate students may be selected, depending on aptitude and inclination." *****

TRUE COPY EXTRACT (Letter, Brig. Gen. Robert C. McDonald, MC, USA (Ret.)
dated 15 April 1948)

***** "(a) Classifications and mobilization of medical manpower for the Armed Forces.

"(1) Comments: Lack of timely classification of medical manpower prior to admission to the Service was a disadvantage to the Medical Service in that insufficient personnel with special qualifications were not made available, or were given improper assignments. Mobilization of medical manpower did not therefore meet medical requirements in the early stages of the war.

"(2) Suggestions: Classification of Personnel should be accomplished as far ahead of admission to the Service as practicable; certainly not later than a pre-induction examination at least a month before induction. Classification of officer personnel, particularly physicians, should be accomplished prior to the beginning of hostilities." *****



L. K. Pohl, Colonel, MC

RECORDED

RESTRICTED

RESTRICTED

TRUE COPY EXTRACTS (from Report of an Exploratory Survey Conducted in 34 Hospitals, entitled "The Interne Looks at the Army", and as made by the National Opinion Research Center.)

"This report is based upon the results of personal interviews with 194 internes in 34 hospitals all over the United States, during the first two weeks of August 1947.

"The survey had three main purposes:

- "1. To determine the interne's plans and expectations for the future
- "2. To study the interne's attitudes toward civilian medical practice
- "3. To study the interne's knowledge and attitudes concerning the U. S. Army Medical Corps.*****

***** "Two-thirds of the internes plan to continue training when their internship is over. Most of the others will enter private practice." *****

*****"None of the internes studied mentions the Army as an ideal career, and none is planning to enter the armed forces on completion of internship". *****

*****"The feeling of social usefulness is mentioned by the majority as the chief gratification from the practice of medicine -- but there is evidence that the nature of their work, their expectation of high financial returns and the prestige of the profession are equally compelling factors." *****

***** "Three-fourths of the internes have seen service in the armed forces, and two out of five have had firsthand experience with the Army Medical Corps.

"Yet only about one interne in five has ever considered applying for a regular Army commission, and only one-tenth of this small group finally decided to do so." *****

***** "But, by and large, the great majority of internes have a definite aversion to Army life, and to a lesser degree, they have an unfavorable impression of Army medical practice.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACTS - Continued - (from Report of an Exploratory Survey Conducted in 34 Hospitals, entitled "The Interne looks at the Army", and as made by the National Opinion Research Center.)

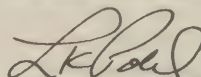
"The reason for this antipathy lies largely in the personal and professional regimentation which they feel must inevitably accompany any life in the Army.

"In contrast, they feel that civilian practice offers them personal freedom and a chance to practice as they wish." *****

***** "Internes feel keenly their need for further training, and the Army is not regarded as a good place to get it. Whatever educational and training facilities there are in the Army should be well advertised.

"Few internes seem aware that the Army treats dependents of soldiers, as well as the men themselves; and many internes complain that there is no variety of patients in the Army. Most, too, have a particular interest in some specialized field, and any opportunities for specialization should not be overlooked in Army information." *****

***** "The shorter hours worked by Army doctors and the opportunities for travel are matters which do not seem worthy of much attention. Long hours do not seriously concern the interne, and the overwhelming majority are much more interested in settling down than in traveling." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain ~~Ernest~~ D. Hightower (MC), U. S. Navy dated 21 April 1948)

***** "(a) Registration of all medical men and women in the United States at a central agency for the Armed Forces, those who are not members of the Organized Reserve to be drafted and allocated to different services by the central agency as need for their services arises. This should aid in avoiding duplication and competition. The first doctors to be called, should be obtained from thickly populated areas with an excessive number of physicians. Confidential files should be kept, not only of all specialists, but also of the more qualified men in each specialty for key appointments."*****

TRUE EXTRACT COPY (Ltr Cdr Martin T. Macklin (MC) USN, dtd 12 May 48)

***** 2. "The failure of the Armed Services to obtain maximum utilization of the Nation's medical resources during World War II may be attributed to the failure of the Armed Forces, in peacetime, to exert strenuous efforts for the establishment of well organized and adequately trained Reserve Medical Units, throughout the Nation. The lack of sufficient Units in number and of trained professional and enlisted personnel to supplement the small available regular Medical and Hospital Corps resulted in: a) General disaffection of a large number of medical personnel in regard to the professional services rendered and what they were capable of accomplishing, under more efficient planning and organization. b) Delayed and inadequate classification and mobilization of available Medical resources. c) Misassignment and misemployment of officer and of enlisted specialists. d) Deficiency in number and the unavailability of small and/or large units for Replacement, Redeployment or emergency use as Evacuation or Auxiliary hospital units.

From the above it is obvious that Reserve Medical Corps Units, adequate in number and efficiently trained in peacetime are essential for the successful accomplishment of Medical Mission in time of an emergency.

It is of general knowledge that there is a reluctance on the part of former members of the Naval Medical Corps to become members of the Naval Reserve and/or to organize Medical Units throughout the country. This reluctance is not only manifested by former medical officers but also by former hospital corpsmen.

From personal contact with physicians in the Philadelphia area, I have learned that the main objection to becoming members of the Reserve Medical Corps, and/or forming new medical units, is the failure on the part of the Bureau of Medicine and Surgery, to give some assurance that organized


L. K. Pohl, Colonel, MC

RESTRICTED

RECORDED

RESTRICTED

TRUE EXTRACT COPY (Ltr Cadr Martin T. Macklin (MC)USE, dtd 12 May 48. CONTINUED :

units would remain intact, in the event of an emergency. The general reply from individuals who are prospective candidates is, "why join or organize an efficient, well trained unit - then in the event of an emergency the Bureau would split us up and assign us to some other outfit (tincans, LST's, etc) as was done the last time. Whereas, if the unit remained intact as organized, trained and a "happy ship", a good job could be accomplished as a Naval Hospital Staff, Base Hospital, on a hospital ship, as an evacuation unit, with the Fleet Marine Force, Auxiliary or Mobile Hospital etc."

Needless to say, there are arguments in favor and against the general attitude as expressed above. However, I do think the Bureau should give some assurance to Reserve Unit Commanders and prospective candidates, that their efforts and aims in peacetime, would be utilized to the same extent as an organized unit in the event of an emergency. Such an assurance would be an incentive to members of county, district and local Medical Societies, hospital staff members and physicians associated with teaching institutions. Reserve enlisted personnel complement may be procured from pharmacy, business or high schools, Youth Clubs, Athletic and Social Clubs affiliated with Church or other responsible organizations. With the cooperation of established Naval Activities the individuals would undergo a course of training and indoctrination from the Medical Officers of the Unit, in the fundamentals and essentials required of hospital corpsmen. A successful policy would assure a basic professional and military training program, which could be readily supplemented by advanced training in accordance with the proposed disposition of the unit in the event of an emergency. On activation the officer complement would be supplemented by Medical Special Corps personnel for Administrative, Commissary, Fiscal, Maintenance Duties, etc.

The classification and mobilization of medical manpower for the Armed Forces should be under the supervision and direction of qualified Medical Officers of the Army and Navy Reserve Medical Corps, with the sanction and support of the recognized city or county Medical Society; without reference to nor jurisdiction of neighborhood, district or county draft boards.

Medical Officers of the Reserve Corps should be cognizant of the qualifications of members of their profession who practice within or in nearby communities; they would also have a working knowledge of the medical requirements for the community; and of the local hospital staff requirements and quota for maintaining and teaching and clinical staffs of local medical schools. This would obviate the possibility of individuals being unnecessarily declared essential to a community, likewise granting hospitals the prerogative of declaring an individual as essential to its staff and finally, prevent deferment of individuals due to their friendship or association with a member or members of local draft boards or because of a lucrative neighborhood practice.

The city or county Medical Society Classification Board (MSCB) should be comprised of senior members of the local Army and Navy Reserve Units, the board members would classify all eligible medical manpower according to their specialty, and the compiled list then submitted to the area Procurement Office. The individuals would be notified by the Procurement Office for interview, physical examination, rank status in accordance with age, and

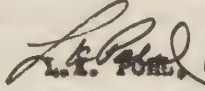
RESTRICTED

RESTRICTED

TRUE EXTRACT COPY (Ltr Cmdr Martin T. Macklin (MC) USN dtd 13 May 48 CONTINUED

professional qualifications and disposition to the service of preference.

In the event of an emergency, the members of the Regular Medical Corps supplemented by the immediate mobilization of physicians who received their education under the V-12 Training Program, should be assigned to emergency billets until such time Reserve Units are prepared and ready for activation. These officers should also be available as replacement (pools) for independent duty sea billets or other assignments, the emergency demands. *****


L. F. POHL, COLONEL, MC

RECORDER

RESTRICTED

RESTRICTED

Extract of Statements made by Brig Gen Robert C. McDonald, MC, USA (Retired),
21 April 1948, before the Subcommittee on the Employment of Military Medical
Resources.

****Regarding the "Classifications and mobilization of medical manpower
for the Armed Forces,"

Lack of timely classification of medical manpower prior to admission to
the Service was a disadvantage to the Medical Service in that insufficient
personnel with special qualifications were not made available, or were given
improper assignments. Mobilization of medical manpower did not therefore
meet medical requirements in the early stages of the war.

What I have reference to there is the drafting of occupational specialists
and assigning them before they were properly classified, or assigning them as
a matter of necessity to combat units who did not need their special qualifica-
tions. However, these units had to have their quota of men, and naturally the
technical specialists were put into these as infantry men or cavalry men, or
according to the necessities of the service, and we had a difficult time getting
those occupational specialists out of there, the combat organization into the
proper medical organizations. I presume that other technical services had
the same difficulty.

My suggestion for the correction of this is assign them. I think that could
be done on the pre-induction examination. I think that we did have late in the
war, or maybe when they got well started on the draft, pre-induction examinations
which were mostly physical. I don't know to what extent they dealt with the
qualifications--that is, the occupational qualifications--of men. However, I
should think that would be the latest time we could get these men classified;
and then when we did call them at a later date, one, or two, or three months
later, no reexamination physically was required. I think we had it up to within
90 days, if I recall. Therefore, these men could be called in accordance with
their qualifications rather than just to fill up numbers. That might require
calling a large number of nontechnically-qualified men ahead of the others, but
I think it would be worthwhile from the service standpoint. * * * *

I think that a national registry of all physicians as licensed by State
or Territory for the practice of medicine and surgery is essential for use as
a basis for timely classification of medical men, particularly the specialists.
Without this, I do not see how a balanced supply of physicians can be obtained
for the medical service of the armed forces. * * * *

"Do you agree that the armed services should rely on the AMA for evidence of
classification of medical officers? ADA? AVA?"

I think that the information furnished by the various professional
associations, such as the AMA, is invaluable. However, we can't rely on that
solely.

"What would you propose doing to avoid the over-calling of medical
officers?"

RESTRICTED

RESTRICTED

I propose timely and careful planning of the medical phases of the armed forces in the campaigns planned, together with a careful estimation of the time element in the development of these plans.

"Do you favor an organized reserve for all of the services?"

I do favor an organized reserve for the services, but I do not think that this organized reserve should include all technical personnel that they may require. I think that the organized reserve is a valuable source of training for certain members of the profession, but all do not require it.

"Do you favor affiliated units for all the services?"

Yes, I think that affiliated units for the services is a valuable way of getting important units ready for mobilization.

"Do you think our present system of classification is sound? Are there any improvements that you would recommend?"

I think the present system of classification is valuable. I haven't thought of the matter enough to recommend any improvement.

"Is it advisable to assign all reserve medical officers to reserve medical units during peace? After experience of World War II, in your mind did breaking up of this assignment develop uncertainty in the medical officer's mind as to the value of our planning?"

We have got to use the personnel to the best interests of the services, and I think that they will have to be reassigned as the conditions of the service demands.

"What is your honest opinion about relying on organized medicine, say the AMA, to furnish medical officers for the services?" ****

What authority did -- I think it was called the Committee on Procurement and Assignment of Medical Officers that was appointed by AMA during the war -- what authority did they have in connection with the calling of the various physicians to the various branches?

They appointed very good men to do this work. For example, in Baltimore Dr. Maxson was in charge of that, and when the Service Command was given a quota of medical officers, he inquired into the situation of the various medical officers who were needed to find out if they could be spared. When he found a man that would fill the requisition, he would put pressure on that man to join up with the service. If the man was essential to the civil community, yet he had special qualifications that the Army particularly needed, he would arrange for a relief in the way of another civilian physician to take his place, and he handled it very tactfully and very well. So I think that while he didn't have any great authority, he was able to put pressure on the younger medical officers by advising them they were liable to be drafted if they didn't, and some of them were drafted when they didn't follow through his advice.

So they have no particular legal authority, but I think they have a great deal of actual authority.

RESTRICTED

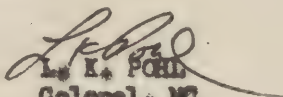
RESTRICTED

Another question. If a national registry of physicians is established and the procurement of physicians is affected through the Selective Service organizations, would the local boards be able to perform the function that you have just described as having been done by the AMA representative in the different communities?

Not without a special provisions being made for that.

Some medical representation on the local board?

That's correct. *****


L. E. FORD
Colonel, MC

RECORDER

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Extract of statements made by Colonel Thomas J. Hartford, MC, USA on 23 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

***** "a. Relative to classification and mobilization of medical manpower, I think that is the responsibility of the National Security Resources Board, and within that Board I believe there should be a group of civilian and military medical people to advise the Board on the classification and mobilization of medical manpower. I believe that any mobilization of medical manpower should be preceded by a classification of doctors within certain groups.

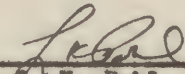
In so far as the allotment between the services, I think that should be on a National Defense level with representatives of each of the services sitting on a committee on that level.

I don't want to make this discussion too long, but I believe that some form of bringing to medical units by echelon is feasible. It's not as simple as some people would like to believe, and I am not naive enough to think that you can fly them to battle and back to the ZI as a matter of convenience to them whenever you are going to fight because -- I mean I think anybody that has had any administrative experience realizes the complications and administrative impossibility of some of the things that have been advanced; but I do believe that some system of echelon is possible. In other words, a unit like a general hospital, that perhaps the chiefs of services, their call might be delayed, say, a week or so prior to POM.

If you are talking about unit commanders, medical, they certainly have to be there with the unit, and you can't bring a commander in the last minute or bring him in at the port. That's just ridiculous. I am talking about purely professional people who are led in the tent and directed to the operating room and operate and come back out of the tent and to the quarters again.

If you are talking about a group headquarters commander or a battalion commander, or even an evacuation hospital commander, if he is going to run that unit at all, he has got to be with it.

I believe within the services that certainly the respective surgeons general should set up a board and determine or recognize certain specialists that may not belong to this specialty group. *****


L. K. Pohl
Colonel, U. S. Army, MC

RESTRICTED

RECORDER

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 Apr 1948

***** A. "Our next big problem, I think, was in recruiting. We feel, and have always felt, that recruiting of nurses can be done most effectively by nurses; but, of course, we have to have assistance through publicity, have funds to provide publicity, and get personnel who can interpret our need to the nursing groups. Our greatest responsibility during World War II was obtained during the period that we had nurses assigned to procurement. At the beginning of the emergency, the Red Cross was charged with the responsibility of providing reserves for the Army. It was not organized for service on as large a scale as was found to be necessary; and, just as they were reaching the point when they could satisfactorily accomplish their mission, the procurement and assignment branch of the War Manpower Administration was set up.

Now, one of our problems as far as that organization was concerned was the fact that they declared many young graduates essential. We had hoped they would allow us to go out and recruit unrestrictedly from the 1945 class. I think it was, but they declared many of those people essential. So it limited our procurement. We had agreed that people who had special preparation and were needed in schools of nursing in teaching programs and supervisory positions were essential, but we couldn't understand how these young graduates would be as essential. No firm program as to our military needs could be announced. Our inability to keep the nursing profession informed as to our needs resulted in an inadequate response. If we could have said to the nursing group that we needed six nurses per thousand troops and held to that goal to work toward, we felt that our procurement program wouldn't have met the obstacles and opposition that it did. I think we were first authorized to procure 4,000 nurses. That was in the early part of the emergency. Then, I believe, it was 6,000 and later 8,000. I know that, at one time during my tour in the office, requirements were set at 50,000 cut to 40,000, and later changed to 50,000, and a draft proposed. This change in requirements caused confused thinking regarding the Army's needs among the civilian nursing groups who opposed the draft. We all felt that our needs could have been more easily met if we could have been fair and open with the civilian nursing groups who were trying to plan for the needs of the Army and civilians.

BRIGADIER GENERAL MARTIN: You expressed your satisfaction with the drafting of nurses. In the event that the drafting of doctors is made a matter of law, would you agree that the drafting of nurses would be equitable?

COLONEL PHILLIPS: I don't think I mentioned drafting of nurses anywhere, General Martin.

BRIGADIER GENERAL MARTIN: I remember that you did.

COLONEL PHILLIPS: The reason it created that impression was that the nursing profession felt there was not just a shortage of nurses; there was a shortage of other personnel in hospitals, and the nurses were taking up the slack in other positions that manpower should be drafted for. If they draft women:-

BRIGADIER GENERAL MARTIN: I am asking you a particular question. If they draft all doctors, would you agree that it would be equitable to draft nurses?

COLONEL PHILLIPS: I think I would say that we had to have that pro-

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 Apr 48. CONTINUED

vision in case we couldn't get them any other way, instead of going back later on for legislation. I had suggested that it be included in the draft machinery there in case we needed it.

BRIGADIER GENERAL MARTIN: What is the present status for wartime procurement of nurses as far as the Surgeon General's Office is organized at the present time?

COLONEL PHILLIPS: At the present time, we are working on our reserve to build up our reserve of 29,000 nurses which will be of a larger nucleus than before. We think that, if we have that group and can be fair with the nursing profession as to our needs, we won't have the difficulty that we experienced before. You see, we had to depend on the Red Cross. The Red Cross just kept a list of qualified nurses for us. When we asked those people to come, their joining the Red Cross didn't mean they were going to be available. Many were overage and many decided they didn't want active duty. If we build up a reserve like the male officers' reserve, if they join the reserve, they have indicated their desire to come on active duty, during an emergency and have a good group to come up with.

COLONEL POHL: How promising does it look at present?

COLONEL PHILLIPS: We are just getting a good start on it. There is a procurement division set up in the personnel division, and we have, at the present time, four nurses assigned. We have two civilian consultants who are helping us with our publicity programs. One of them is also taking over the medical department program now. We have about, I think, 5000 signed up in the reserve. I read some reports this morning. We have one of the consultants on a trip now following up our program, and it is interesting to see that, in some areas, she feels there isn't too much enthusiasm for the program except within that area to get personnel for themselves. There is misunderstanding among the civilians and opposition from the hospitals because of the fear that we are going to take the people from them. When we can get out and explain what the purposes of the program are, it changes their attitude.

BRIGADIER GENERAL MARTIN: Are you experiencing any competition from the Navy or other federal nursing services?

COLONEL PHILLIPS: I don't think so. I haven't talked with Capt. DeWitt. I think they are having the same difficulty we are.

BRIGADIER GENERAL MARTIN: To what extent can the partially physically handicapped nurse render service, especially in hospitals of the zone of interior during the war?

COLONEL PHILLIPS: With the limited numbers that we have for staffing, I would be reluctant to take people on who were not able-bodied personnel. Now, those with poorer eyesight might be kept on limited service back here, but certainly a nurse has to have full use of her arms and legs; she has to hear well; and, if she is not physically fit, she becomes an added burden to us because she is hospitalized.*****

RESTRICTED

L. E. POHL
L. E. POHL, Colonel, MC

RECORDED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E.R. MERING, JR., (MC) USN ON 22 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** A. "A National Registry of all Physicians as licensed by State or Territory for the Practice of Medicine and Surgery. Along that line, as it affects me in my employment in the service right now on the job I have, this Registry would certainly serve a great purpose. For instance, if we were mobilized immediately, I want to have back with me in this particular employment of amphibious warfare some of the officers who I know have had experience along that line and who would be qualified to act in some of these billets. And therefore, a National Registry with their qualifications and background would certainly seem to me to be essential. I feel we should not lose track, especially of those officers who served in the last war and who were outstanding and who can accomplish or hold certain positions."*****

L. K. Pohl
L. K. POHL, Colonel, MC
RECORDED

TRUE COPY EXTRACT (Letter, Brig. Gen. George R. Kennesbeck, DC, Air Force, dated 7 May 1948)

***** "Dental manpower in a future emergency should be classified by the dental profession of each State according to military and civilian needs. Military Committees of State Dental Societies should be appointed and they should advise local Selective Service Boards as to the dental needs of each community. Dentists selected for service, or exempted from service, by local boards should be cleared through the State Society Military Committee. It is my opinion that physically qualified dentists who have not passed the fortieth anniversary of their birthday should be considered as eligible for active duty in the Dental Corps in an emergency. This State Society Committee should also be concerned with the specialist qualifications of dentists in their State and determine those available for military duty and those who should remain in civilian life."*****

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, on 15 April 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

"I think doctors should be imbued with the idea that they have professional responsibilities to fulfill whether in uniform or not. I think maximum use should be made by the armed forces of professional services in various localities. This may lessen the number of doctors required in the armed forces and result in a more equitable distribution between armed forces and the civilian population. It applies particularly to specialists. They might utilize the services of specialists in a particular area."**** Certification by American Specialty Boards should not be the only criteria by which specialists are selected. Specialty Boards are relatively young and therefore they exclude a large group of doctors of over ten years experience who never have a chance of becoming certified by a Specialty Board. I think that screening boards should be set up in peacetime to categorize all doctors in the U. S. according to age, physical condition and professional qualifications.

***** "3. Yes, but I think some military personnel should be members of the Board.

"4. I believe that the Selection Board that we have spoken about would be the agency to make the decision based on overall strength of the services and each service should be allocated an appropriate number and that would include the Public Health Service, along with Army, Navy and Air Force."*****

***** "6. Yes. I am particularly in favor of affiliated units but formed and utilized early in theatres so that when the pressure gets greater they can be spread out to other units and other units can utilize their war experience.

"7. I would only form up the basic unit of the hospital and allow other people to remain on-the-job training until they are needed."*****

***** "12. I think they should be promoted on the basis of professional advancement during peace."*****

***** "(C) I would categorize professional personnel as to age, physical condition and professional qualifications by a combined civilian and military medical board. That Board could determine the overall requirements for the military service including Army, Navy, Air Force, Public Health, Veterans Administration, and civilian medical service."*****

***** "(H) 18. I do not favor any reduction in physical standards for acceptance of commissions mainly because of the present laws in force regarding retirements. If the laws could be changed suitably I believe the physical standards could be lowered as far as doctors are concerned."*****


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY

(Letter from Capt. Warwick T. Brown, (MC), USN
dated 20 April 1948)

***** "a. Classification and mobilization of medical manpower
for the Armed Forces.

For wartime mobilization and classification -- no comment.
For the long haul procurement of medical officers for the armed
services, it is suggested that medical school scholarships be
offered in connection with the ROTC programs in the various colleges.
The period of obligated service to be at least equal to the time
spent in medical school, *****



L. K. Pohl

Colonel, U S Army

RECORDED

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY (Ltr from Dr. Wm.C. Menninger, Topeka, Kansas, 22 Apr 48)

***** B. "If we came to an emergency at the present time we again would be short of certain extremely important specialists. I speak with special attention to neuropsychiatrists. The military must have prepared ways and means for training many of the younger men who would come into the army at the ASTP level in this field. Therefore, we must have schools of a minimum of three months duration to provide this training."*****

L.K. Ford
L.K. FORD
Colonel, MC

TRUE COPY EXTRACT (Ltr Rear Adm F.L. Conklin (MC) USN, 27 Apr 48)

*****A "All Medical Officers should be classified as to professional and administrative ability, and be mobilized from a pool."*****

L.K. Ford
L.K. FORD, Colonel, MC

RESTRICTED

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic B. Westervelt, MC, U.S.A., on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

***** "I feel definitely that all medical personnel should be classified and that the classification must come from a reputable source such as the American Medical Association, because my experience has been that you cannot rely on individual questionnaires. The average doctor tends to overestimate his experience in certain fields, or he will enter his supposed ability in certain fields because of the fact he feels that this questionnaire may temper the type of assignment he is going to get.

"The doctor should be classified by an over-all at least reasonably impartial agency.

"The Surgeon General's Office very definitely should do that for people who have military records. There are thousands of doctors that the Surgeon General's office has no knowledge of and he couldn't possibly classify. I was thinking of medical manpower as a whole, country-wide.

"If the Surgeon General's office could get an accurate appraisal of the professional experience of the medical manpower, then I think the Surgeon General should make this classification; but he is not going to get it from the individual doctor. He will have to get it from an agency like the AMA, and then superimpose or add to that for the necessary classification that he sees fit.

"As far as a national registry of all practicing physicians, dentists, veterinarians, and what not, I consider it necessary and an immediate need. I can't conceive of intelligent use of professional talent until there is a registry of these individuals. Regardless of how that talent may be called or the composition of the various boards, someone must know who these people are, where they are, and all about them professionally and militarily. And since it hasn't already been started, I think it should be started at the earliest possible moment.

"All I can say about Selective Service, about which I know very little, is that whatever system is used to handle it, Selective Service should have a medical staff agency incorporated into it, and it should certainly have ample civilian representation. I don't know whether it should have a civilian head, or not, but it should have civilian representation, because it ties in with civilian doctors."*****

RECORDER

L. A. Paul, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

***** "No. 5. Yes, if. I do favor an organized reserve for all the services, providing the reserve people, particularly from the medical angle, can be assured that it will be worth while to be a member of the reserve corps. If they can be assured that their interest in joining the reserve will result in at least equal consideration at the time of mobilization rather than the advantage apparently at least going to the hold-out, to the man who plays hard-to-catch, then I am in favor of a reserve, and our reserve is not going to be successful medically speaking until something can be put in writing and there can be a reasonable guarantee of its being fulfilled; that your being a reserve officer shows that you have done this in good faith, and we will protect your interest, and we won't take this man who is not interested in the reserve and promote him over you or bring him in at a higher grade than that which you have just because he is playing hard-to-get and we need him at the moment.

"No. 6(A). I feel that affiliated units for all services are a fine thing for immediate stages of mobilization. I don't believe these units can, under the present circumstances, be given much training, but they are something. They are a stopgap. They are a beginning for any emergency that happens in the interior, and they certainly are a readily-available unit for dispatch to an overseas theater.

"The big arguments presented against them that you can't maintain the integrity of the unit in particular—that is the chief argument—isn't as serious as it sounds because on the face of it individual members of the units don't present any serious objection to being transferred out providing they can get a position of greater responsibility or get a promotion from it.

"In answer to question 7, this has been partly answered by avoiding an improper call-up of medical officers. We should avoid calling medical officers until we need them. This can be done partly by a knowledge of when we are going to need them and partly by a proposed plan of echelon medical-type units into the training phases, so that we don't put the professional people into those units until just before the units are going to be utilized.

"We can go through part of the activation phase of a medical unit with a minimum number of doctors and then add the doctors, particularly the highly-qualified professional members of the team, only at the time that they are going to be needed."*****

RECORDER

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

***** "(M) 5. I think some of the steps that should be taken now to prevent some of these mistakes would be first of all this classification of doctors nationwide; secondly, a development of an echelon-type of building up, an echelon method of building up a unit so that the professional elements of the unit wouldn't be called in until they were going to be needed; and even with this provision that the professional people be kept busy by being put where they can be used and not be allowed to hang around inactive units."*****

"(M) 13. That is difficult to answer in view of the present feeling of the Surgeon General, our Surgeon General, that people should be given rank based upon their length of medical experience. They are talking and are actually presently integrating people direct from civilian life and giving them an advanced rank merely because they have been out of medical school for a certain time, and they are doing that to the detriment of people who are actually in the service. I don't approve of it personally, but that is entirely my personal opinion. It does not represent the opinion of the front office."*****

"(M) 15. I see no objection to subsidizing medical students any more than there is objection to subsidizing students at West Point and Annapolis. There doesn't seem to be any stigma attached to a graduate of West Point or Annapolis, and he has been subsidized for his college-type training and therefore I don't see why there should be any stigma attached to subsidizing a man for his professional education. It's a new thought. It's very controversial, and I don't know what it's leading to, but I personally see no objection to it.

"(M) 16. In view of the shortage of doctors and medical officers, if we are going to prevent some of these potential doctors from becoming doctors by drafting them before they graduate, I think we then should justify taking some measures that will exempt them from being drafted while they are continuing their medical education. If that involves commissioning them as second lieutenants in the MCC, I am in favor of it. I am in favor of something to keep potential doctors from being interrupted in their studies. I don't think it should be carried too far. I don't think it should be carried to premedical students or to a degree that would encourage people to go into the study of medicine purely from avoiding being drafted, but I think once a man shows that he intends to go into the study of medicine, then he should be permitted to continue that study.

"(M) 18. I do favor a reduction in the physical standards because we have to use more men than we have in the past. Our manpower can't be stretched any further, and we have to adapt the jobs to the people or adapt our standards to the physical limitation of the people we have in this country."*****

RECORDED

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF INTERVIEW WITH COLONEL VIRGIL CORNELL, MC, USA, 30 April 1948

*****A. "Under item (a), "Classification and mobilization of medical manpower for the Armed Forces"; First, classification should not be overdone; the need for basic medical officers is too great. Second, the preliminary psychological build-up for all medical men is needed to induce them to accept that fact. It will reduce the difficulties discussed under (1). Register all medical personnel, including affiliated units, in order to avoid weak and strong units. That is, we have found, and I am sure everyone realizes, some units with a lot of good men in, other units with very weak spots.

Next, require the high grades, particularly in affiliated units, to acquire some elements of basic military training as preparation. Too many times the senior professional officers did not have enough acquaintance with military procedure and staff work.

It is presumed that rosters of all medical specialists and allied sciences are available. If not, they should be carded. Parenthetically, just before the last war, we worked on the roster of the artists and photographers of the country through their national societies, and it was only by that that we had available these people of the medical arts units, knowing their family situation, their age, their capabilities, and so on; and I believe much information can be gained by the people they are working with now while there is time and know what these people are capable of if we need them. That, of course, has been worked on from the angle of physicists; I think it should be carried into all of our subdivisions such as we were speaking of, bacteriologists, and so on.

Choose representatives for medical school details with a view to their personality and salesmanship. Too often a man is sent to a school because it was his school and he is a little tired, perhaps, of professional work and would like to teach somewhere. I think that is one of our most important sources of officer material.

REAR ADMIRAL ANDERSON - OFF THE RECORD

COLONEL CORNELL: I think it's one of our sources of our best material and our incoming material. In other words, the impression made on the young men in medical school by the PMS&F's is most important to our acquisition of good men. Along that same line, send some of our keen young men to such schools for post-graduate work as examples to the undergraduate body.

Encourage religious objectors to prepare as medical assistants; for instance, the Seventh Day Adventists. Recently one of my former sergeants, who is now dean of men at one of their schools, wrote and asked if they could arrange with the Surgeon General to substitute first aid and medical work for firing and rifle drill. I think that sort of thing should be encouraged because they make good soldiers and some of them good officers.

Register all medical and premedical students and graduates in separate files as a source of material so that we can know that is coming along in the way of officer material. I think that should be carried further than the Adjutant General's office. It should be carried on so that the Surgeon General's office knows what these men are.

RESTRICTED

RESTRICTED

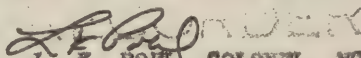
TRUE EXTRACT COPY OF INTERVIEW WITH COLONEL V. CORNELL, MC, USA, 30 April 1948
A CONTINUED:

Preliminary mobilization in separate camps for basic training, probably sectional camps, and then assign to training centers according to units for special training, but not too many units in one place for the training facilities.

I would like to expand that just a little. I had a large laboratory unit. All the laboratory units were at Fort Sam Houston for training. There weren't enough facilities there to train all laboratory personnel in their specialty. We could do our basic training, but it wasn't until just two weeks before we were alerted that we managed to get a small laboratory building that we might send our men in to do laboratory work.

Screen Medical men as well as to their basis of training and previous experience before assignment to units.

I might quote there. I have talked with one of my assistants who was a division surgeon in the South Pacific and he stated that when they received their officers from Carlisle they came in all the way from B to E, or something like that, and F to H were sent to general hospitals, or something. Consequently they got specialists and they got men who weren't suited to frontline duty, and that lost them after awhile because when that was realized they were pulled out and sent back to other units; so time was wasted and training time was wasted.*****


L. K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC)USN
ON 4 MAY 1948.

***** A. "REAR ADMIRAL ANDERSON: Following this outline, could you offer comment on what you feel might have been some deficiencies which might be improved in case of another war? For instance, beginning with "(a) Classification and mobilization of medical manpower for the Armed Forces", do you have any suggestions to offer about classifying and mobilizing doctors, nurses and other members of the medical services?

I might say, to give you some insight into what the committee has been discussing, that we feel that the classification of medical officers should be uniform in the three Services - Army Navy and AirForce - in order to facilitate the procurement, which properly, we think, should be a joint procedure. For instance, if in the draft all doctors are registered and if then they could be classified, obtaining the necessary information on specialty, age, dependents, competency in the specialty - if that classification could be uniform for the three Services it would facilitate the procurement of personnel. We feel that an accurate classification is necessary for intelligent assignment.

REAR ADMIRAL WILLCUTTS: But by classification you don't mean necessarily job analysis. I think the Navy will require medical personnel, just as the AirForce will and just as the Army will.

By classification do I understand you to mean to classify these doctors as general practitioners, as surgeons, and so on?

REAR ADMIRAL ANDERSON: That's right.

REAR ADMIRAL WILLCUTTS: For hospital work of course I think that could be done, but in the field I don't know. Job analysis - filling the Navy billets - I think definitely will be distinctive from the sister Services to a degree. I mean, after all, submarines and special weapons that we all hear about will involve specialized medicine distinctive to the Army, Navy and Air Force.

REAR ADMIRAL ANDERSON: As a basis of medical personnel supply, would you consider it logical to have a basic classification upon which each of the Services could then act in supplying further training, or, in individual cases, take the officers who are considered qualified sufficiently for assignment without training?

REAR ADMIRAL WILLCUTTS: It is difficult to make a general statement unless we know what the pattern of the next war that we fear and anticipate will be. We know it will be total war and will involve civil defense. There, again, you have specialized weapons. I think, definitely, classification must include not only the needs of the Services but keeping in mind always civil defense.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USN
ON 4 May 1948, A CONTINUED:

There comes in any Service a matter of esprit de corps, of choice. Our doctors are medical officers, and I don't believe they can be regimented or classified into a commodity, may I say, like perhaps our fighting forces, our enlisted personnel.

We have in our Navy 14,000 reserve medical officers, which, should they all come back - and most are available to come back; a few are getting into the 50s - would serve our needs for a tremendous Navy, for a 4,000,000 man Navy. But can you think of a 4,000,000 man Navy in the next few years? No! We have now a Navy that is the biggest in the world, with a half million people.

What are you going to do with our naval reserve officer who likes the Navy? They like the Navy better than the Army or Air Force, or they wouldn't have been in the Navy, just as you people have adherence to the Armed Forces - to the other groups, the Army and Air Force.

If I may explain that more, the Army, as I understand it, if I may speak on the Army as I get it, had the bulk of the Army based upon a group classed as AUS, Army of the US. And upon demobilization that group went home. The doctors demobilized separately and did not constitute an Army Reserve.

Am I right on that?

COLONEL POHL: I believe that is correct, sir.

BRIGADIER GENERAL MARTIN: I would say the bulk did not join the Reserve.

REAR ADMIRAL WILLCUTTS: You demobilized and they were separated. Our people didn't do that. They went right on into the Reserves. We have established a very close contact with that group, that 14,000 and we have them in great divisions throughout the country. We have 280 divisions for M-Day; and 240 divisions will have 75 doctors per division. We hope to have 18,000; at the present time we have 14,000.

Now to classify these doctors all in one, big pool would demoralize our Reserve, I think, because the Reserves are peculiarly Naval in choice. I would hate to see them all thrown into one, great American backlog of medical power and say that we had 14,000 doctors. In the last war we had those 14,000 doctors in the Navy, and you had 60,000 in the Army. I would hate to see them messed up in one, big pool.

We are active in our Naval Reserve. Fortunately we did not demobilize as you did. You didn't have the same set-up. You had the AUS. In the same manner we have more regular doctors than the Army. I think the Army has something like 1,200 doctors; we have close to 1,500 and 100 in the process of coming in. We will have 1,600 in a few weeks. We know we will have 1,600. That is odd when you think the Army is ordinarily three times the size of the Navy. But it is not odd if you stop to analyze it.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USE
ON 4 May 1948, A. CONTINUED:

The Army during the war went AUS rather than Regular or Reserve. The Navy maintained an active recruitment and enrollment into the Regulars all through the war, so that we obtained 1,000 Regular doctors during the war. I don't believe the Army had ever 100, I am told, roughly that, not on any competitive basis, nor any reason like that, for that was not the scheme of the Army. We had, I would say, an input of 1,000 Regular doctors during the war; in other words, we went to 2,000 Regular doctors.

REAR ADMIRAL ANDERSON: As the Subcommittee has been considering this subject of classification, it has not been our idea that classification would mean a redistribution of medical officers. As I understand the term, it refers to a record in the Office of the Chief of the Bureau of Medicine and Surgery for each member of the reserve and each regular officer.

REAR ADMIRAL WILLCUTTS: That's what we have now.

REAR ADMIRAL ANDERSON: That will indicate what his qualifications are, so that when he is mobilized he can be intelligently assigned.

REAR ADMIRAL WILLCUTTS: Surely, if you classify them per force. Our 14,000 are classified not only by name and address but also by professional cards that are kept up.

REAR ADMIRAL ANDERSON: To go to the matter of mobilization, as I understand it the Navy at the present time is in a position where in case of mobilization the requirements for medical officers could be filled from our Reserves.

REAR ADMIRAL WILLCUTTS: That's right - our Reserves plus recently re-signed Reserves who have never served actively in the corps.

REAR ADMIRAL ANDERSON: Do you have any comment about procurement of medical officers through the selective service draft?

REAR ADMIRAL WILLCUTTS: During the hearing it was brought out that never has a doctor been drafted in the recent history of America. They weren't sure about the Revolutionary phase. The statement was made and accepted that doctors are never drafted, and that I believe is the feeling of the American Medical Association and organized civil medicine. I think the doctors will be the very first to come forward, should we get into a true national emergency; and to draft them will really not be necessary. I think the mere registration will bring forth all that we need in the Navy.

REAR ADMIRAL ANDERSON: There is another feature that should be considered in connection with the drafting of medical officers - I would like to have your idea - and that is that with new methods of warfare, atomic bombs or other methods of warfare, the demands of the civilian population for doctors will be greater than it was during the last war. As one can visualize in case of attack by air, the need for doctors in civilian life might be very much greater than it was during the last war when no such attack occurred.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USN, 4 May 48
A. CONTINUED.

My conception of the draft is that it would provide a means of calling doctors into the service in an orderly manner. The draft would be administered by the local board, which would be in contact with the local situation; and doctors selected could be selected for the service on the basis of the ability of the community to spare them.

REAR ADMIRAL WILLCUTTS: I don't quite follow you. First you don't draft an officer, and then you would have these doctors drafted. These doctors would be officers. The mechanics of drafting a medical doctor would be to make him an enlisted man, because that is what a draft does. Well, I can't conceive of any of our doctors being drafted.

REAR ADMIRAL ANDERSON: That would be true of the draft bill under consideration now, would it not?

REAR ADMIRAL WILLCUTTS: No. The draft bill will provide for the procurement of doctors to meet the services' needs from age 45 down. If they are drafted, they will be drafted as apprentice seamen in the Navy. But they will be registered and will come in and be activated into their officer commission according to rank, and so on.

REAR ADMIRAL ANDERSON: That is the idea I was trying to make clear - that it is necessary through some agency to have a National Registry which will indicate what medical manpower we have, so that that portion of it that is needed by the military services can be selected without upsetting the doctors remaining for work in the civilian community.

REAR ADMIRAL WILLCUTTS: I have been in close contact and in committee with civilian medicine, with the Committee on National Emergency Medical Services, and they make a very definite statement in that Civil Defense that in the civilian economy today the doctors run about 1 to 750. They said in this committee that they feel that they need that many doctors. They had a horror of going back to 1 to 1,500, as they claim it was during World War II. A very happy average, they thought, was around 1 to 1,200. The Secretary stated 1 to 1,250, but the members of the committee didn't like it. The Secretary was very earnest. Dr. Mieling gave it a lot of thought, and he thought 1 to 1,250 would do. So we will have to have one grand classified job so that we in the military do not again take too many doctors and so that Civil Defense doesn't hold too many of them.

REAR ADMIRAL ANDERSON: Could you give us an idea as to whether sufficient medical officers could be obtained for the Services if in civilian life they would retain doctors at the rate of 1 to 1250?

REAR ADMIRAL WILLCUTTS: I think so. I think it could be done, and today without great disturbance of the medical situation because so many young doctors are still engaged in post graduate work and have yet to establish themselves as

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USN
4 May 1948. A. CONTINUED:

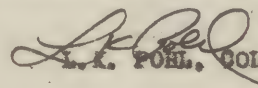
practicing physicians. Our greatest pool would be these youngster who have not yet become fixed in the community. And, I don't believe the communities are suffering too much at the moment. Certainly there are enough doctors, if they were distributed properly. Some doctors are denied hospitals because they want clinical medicine on the level of their teaching. They don't want to go out and be the General practitioner, saddle-bag doctor of the old days. I believe if the rural districts had medical facilities we would have plenty of doctors in America.

REAR ADMIRAL ANDERSON: Do you feel that the medical services had too many doctors during the last war?

REAR ADMIRAL WILLCUTTS: I do not think so - definitely I do not think so. The Navy at the peak load had 14,000 roughly. And at that time we had in the Navy and in our Marine Corps over 4,000,000 personnel, which gives a ratio of something over 3 per 1,000. The law provided us with a formula of 6-1/2 per 1,000. True, in the Pacific, as I am sure Admiral Anderson will bear out in the fleet, I would go visit a little ship, an LST with, say, 3 or 4 doctors aboard and nobody sick. These doctors were chafing at the bit, wanting to do something, and yet they failed to appreciate the Naval need for these doctors on that LST had the enemy been more powerful. We did not know that Japan was folding up so rapidly; we didn't know that Germany was going to fold. What if the Bulge had succeeded? What if we had to invade Japan? We would have been yelling for these doctors.

You have definitely got to have more personnel than you actually need if you are going to win a quick war. By having these doctors, by having this strength, not only doctors but all classes of American manpower, we overwhelmed the enemy rapidly and saved many, many man hours of medicine, I think.

REAR ADMIRAL ANDERSON: Are there any other questions that occur to either of you people in connection with this subject - classification and mobilization?*****


L.R. FEHL, COLONEL, MC

RESTRICTED

RESTRICTED

ABSTRACTED FROM PERSONAL LETTER TO COL. L.K. POHL, MC, FROM COL. E. BRUNQUIST, MC,
DATED 19 May 1948.

***** A. "In handling the Reserve program, it is imperative that the former mistake of penalizing Reserve officers by early calls to active duty, and then promoting non-Reserve civilian doctors at a faster rate, or commissioning them in higher grades, be abandoned. In order to stimulate interest of the Reserves, the active duty tours should consist of very pleasant indoctrination, including cocktail parties, airplane rides, and cordial reception by all concerned, including Line officers. No attempt should be made to occupy their time with dry lectures about field sanitation, paper work, etc. They should not be made to demonotonous physical examinations for two-week-periods, or other menial jobs. They should look forward to the two-week period as a vacation with pay, and should be allowed to have their wives and girl-friends in close attendance, if desired.

The Medical officers in charge of the Reserve program should be selected for their enthusiasm, integrity, and professional attainments. The old system of putting a man on Reserve duty to get rid of him, should be abolished. Reserve officers should be included the year round at the regular Officers Club, and should be encouraged to socially participate in Club affairs.

The ROTC system in Medical schools should be abolished, and medical students should be put in the Medical Services Reserve Corps, and treated like other college graduates, as Reserves on active duty, for which they can now be paid. The Navy has long since recognized this fact.

Another unfavorable policy which discouraged our Military doctors is one which would not allow qualified men, at station hospital level, to render medical care of a type of which they were capable, and which, in civilian life, would have been considered commonplace. Putting a mediocre man in a general hospital does not make him more qualified than a superior man in a station hospital. The Medical Service should not be by inflexible policy direction, but by close supervision of competent hospital commanders.*****


L. K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA,
13 May 1948)

***** MAJOR GENERAL KENNER: In answer to this first question -- classification and mobilization of medical manpower for the Armed Forces -- it should be done by coordination with the civilian agencies, either through the AMA or local medical societies, the Surgeon General to list doctors with their respective MOS and establish rank accordingly. Obviously the only way to secure information on Dr. Jones in Altoona, Pennsylvania would be through some civilian agency, preferably a medical society, lacking any information in the Surgeon General's Office that might have accrued through the war years.

It would seem to me that the Surgeon General could earmark these people for certain jobs and establish their rank in conformity with their MOS. For instance, an outstanding general surgeon would be given a 3150-A category and would therefore be eligible for assignment immediately in the grade of lieutenant colonel in a major installation as chief of the surgical service.

I believe there should be an integrated medical staff at the National Defense level to place requisitions for medical personnel for the several components with the procuring agency, the civilian agency, all doctors to be earmarked for assignment either military or civil. The determination as to whether certain doctors are going to be eligible for military service would rest with the local agency, the local medical society or maybe the AMA. I don't know what part they would play in this, but certainly enough doctors would have to be left behind to meet civil requirements.

Another thing, too, it is apparent that a doctor called to service in the Armed Forces would be sacrificing much more than the doctor who stayed at home. Therefore, the local medical society should take measures to protect this doctor's practice. Now whether there would be a rotation after one year's service in the Armed Forces, whereby this fellow could be relieved by somebody who had not been called, is something that might be considered.

There should be development of a proper corps of medical reserve officers with an adequate promotion system and in active duty pay. The Reserve Officers' Association is working towards that end now, and the 281 Law also contemplates a one-half percent per year credit for retirement age 60, as you all know. I see no reason why the medical reserve officer may not be given the same advantages and why he may not, in order to get full credit, be called to active duty for limited periods -- 30 days, 60 days, or 90 days -- and for duty within his own residential area.

If there are no further questions on what I have said, and if what I have said is clear, I will go on to the next question.

BRIGADIER GENERAL MARTIN: Would you favor a National Registry of all medical personnel resources?

MAJOR GENERAL KENNER: I think that is the only solution to the

RESTRICTED

RESTRICTED

- 2 -

problem. Obviously in the kind of war that we contemplate there is no longer a combat zone; and civilians are just as susceptible to atomic bombing and everything else that may come along in another emergency. I think all medical services, your hospitals and everything else, must be taken over at this National Defense level. Utilization of all of our resources to the best advantage is so obvious that I don't think it requires any argument."

BRIGADIER GENERAL MARTIN: I think that's the picture." *****

***** MAJOR GENERAL KENNER: "I would like to preface my remarks by stating that I believe that there has been too much emphasis placed on professional specialization, having in mind that the primary mission and the essential mission of the medical service, whether it be Army, Navy, or Air, is the medical support of troops in the field. The reason for having the medical corps, and incidentally of having an army, is to prepare for war. I therefore believe that we should establish a specialist MOS for the military surgeon with a 50 percent increase in base pay to compensate for hazardous duty to which the medical specialist is not subjected in 21 hospitals, for instance, and to compensate for the denial of opportunity for professional advancement for those officers who are attached or assigned to field units. I believe, furthermore, that the T/O&Es should be modified as follows: battalion surgeon, major, with an MOS of "d". That is the category of specialist MOS. The regimental surgeon should be a lieutenant colonel with an MOS of "c"; the division surgeon, a colonel, with an MOS of "b"; and the army surgeon, a brigadier general, with an MOS of "a". Your theatre surgeons and surgeons of major commands, depending upon their size, may be major generals.

I believe we should establish a system that more or less imitates the British System of automatic rank within the assignment. We all know that many an officer has been assigned to a job that calls for a higher rank than that held by him at the time. Due to administrative delays it may be months before he is promoted to the appropriate rank. I believe, therefore, that with proper selection an officer who is assigned to a job that calls for a certain rank should automatically get that rank when he reports for duty. We have seen some instances, particularly with reserve officers, where there was assignment to a position that called for higher rank and yet they were not promoted, which is one reason why the reserve is so critical of the Regular medical officer. They have seen the younger Regular step up a couple of grades while they, in a position calling for a higher grade, marked time in a lower one.

I may say that we have precedent for this 50 percent increase in pay. A submarine officer in the Navy gets it; the Air Corps officer gets it. And we have already recognized the fact that assignment of medical personnel with troops is extra-hazardous because of the 10 percent combat pay.

RESTRICTED

RESTRICTED

- 3 -

The argument that may be advanced against this may apply to our surgeons in the higher echelons, but there again we have precedent because we know that general officers of the Air Corps on purely staff assignments, required to fly four hours a month, continue to draw flying pay when everybody else on the staff is flying as much or more than they are and getting no increase in pay.

BRIGADIER GENERAL MARTIN: Do you favor a uniform system of national scope wherein all specialties are classified similarly, and the adoption of that system by the Armed Forces?

MAJOR GENERAL KENNER: I don't think it would be worthwhile unless there was formalization and standardization of the parts that determine the specialty.

Rear Admiral Anderson: In your concept of the control of the national medical resources, is it not imperative that we discard the prior voluntary system for getting doctors for Federal service?

MAJOR GENERAL KENNER: I am of the opinion that the only way to meet the national commitments for medical service, civil and military, is to do away with any volunteer system and to draft every doctor for some function either within the military or within the civil society. *****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH BRIGADIER GENERAL JOSEPH E. BASTION, MC, USA
(RETIRED) ON 3 May 1948.

***** A. "BRIGADIER GENERAL BASTION: With reference to (a). I believe that the medical manpower and womenpower of the country should be classified in such a manner that on M-Day they can be called in like any other classified group.

In order to do that, some central agency should be set up, a National Registry, or some other name, but these people, the professional group, should be made to understand right from now on in that they will be called as necessary for the work that the board or the agency think they can do; and there must be a setup there so that the civilian population can be taken care of. And I believe that the whole professional group should be taken up to the age limit agreed on, and that they could be sent to any civilian community to help out just like they would be sent to a post or station.

You can't work it any other way. In other words, as General Martins says, there must be a central agency to classify these people according to the way the Armed Services with the classification.

One thing that I have thought about, the high command, or medical command of all the services, goes through every year, year, year worrying about where they are going to get their personnel - I mean, professional personnel. And I think the time is coming to think about it anyway, that we should subsidize professional services something like the Naval Academy, or the Academy at West Point, and take these people from pre-medical -- I don't know just how it would work, get them in and pay their tuition and maybe give them a commission in the reserve during those four years; but the idea is that you would build up your pools then for years and years to come. And they should be kept a certain time -- I don't know, five years would be the minimum afterwards before they are permitted to go out; but I think it would do away with this business of the higher echelons worrying about where they were going to get their professional personnel.

I think right now - I don't know - just from talking to younger doctors and dentists, a few I see around, somebody is promising them an awful lot. Now, I don't know whether it has really been promised. They will come in the service for two years and don't have to do anything but that little professional job right there, and at the end of that time they can take their board. Who at these posts or on your ships is going to take care of the big mass of our people, the enlisted personnel?*****


L.K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

D-1b. PROFESSIONAL AND MILITARY EMERGENCY TRAINING PROGRAMS WITHIN THE ARMED FORCES.

I. GENERAL

Because of the mission of the armed forces during peace, the discussion of this subject cannot be restricted only to training of medical personnel during mobilization and in war as implied in the verbiage the directive. The training of those who must direct, control, and operate the medical facilities of the services during war is considered the prime responsibility of the peacetime armed forces.

The premise that prewar training of all medical personnel for their war assignments is the ideal method of insuring best results in all medical fields is sound and should be accepted as the basis for the pursuance of all prewar efforts in the training field.

The intangibles associated with the rapport between unit medical officers and their troops, including commanders, is no less than the patient-doctor relationship in civil life and a most important factor in service medicine. Combat troops admire and depend upon their medical men to a remarkable degree if they are known to be qualified. This dependence cannot be developed in a few hours and indicates that adherence to the previous policy of assigning doctors to combat units during the latter phases of their unit training is sound. To change this general policy would be dangerous in any future mobilization. It has been suggested by some that doctors should not be assigned to any unit until that unit is ready for departure for combat. This is false in the case of non-medical combat units in that it denies the necessary training to combat medical officers who will surely be incompetent in their important duties without that specialized training.

There is preponderant evidence to substantiate the need for military training of all doctors for the military part of their duties in war early after joining. Highly specialized individuals may possibly be excused from some of this training but only on an expediency basis and not on the assumption that more complete military training would not materially improve their overall efficiency as members of the armed services.

Much of the criticism of military training on entering the services stems from a lack of understanding in the case of medical officers that they are military officers as well as physicians and that the morale and discipline of the ranks in their units is dependent upon their attitudes and knowledge of military affairs as officers. Justifiable criticism has been made of the misassignment of officers trained in specialties during the war after the completion of their special courses. This resulted from poor planning of requirements and should be prevented in the future.

RESTRICTED

RESTRICTED

There is universal accord in the necessity for utilizing the time available for post-induction training to best advantage. Military exigencies will always play a dominant role in controlling that important phase in mobilization. Training programs must be so designed to permit of giving essentials primary importance early in training periods. Past experience indicates that certainties of the available time cannot be determined with finality because they are dependent on the uncertainties of war in which the actions of an enemy play a large part. The atomic bomb threat poses a problem which may well prevent any time for training.

Too much reliance should not be placed on the stockpile of experienced officers and men who served during World War II in the medical services. Admittedly its value is great but each day reduces its effectiveness in numbers, physical status, and military knowledge. Progress in the military has only been achieved by change and there is much new today that World War II veterans are totally ignorant of in each of their former military fields. We cannot assume that the stockpile is fully qualified to jump into any future war to perform without additional training.

World War II produced for the first time in our history an excellent scheme for the training of most components of the medical service. It has been universally recognized as producing superior results and there should be no deviation except for minor improvements in the major methods used for accomplishing the results.

The question of training of the medical reserve components during peace is a knotty one. Undeniably it should receive intensive study and action. It appears that individual incentive will continue to form the keystone to progress in medical-military education. Recognition of this voluntary effort to improve individual knowledge in this field must continue in any system devised to prepare reserve medical manpower for war. Reward for this effort in preferred assignments and with advanced rank must be tempered by the obvious fact that theoretical knowledge cannot alone be the index to any individual's capabilities to perform adequately in military position. Actual experience will always remain the most important element in the overall or specific value of an individual to the service. Means to give medical-military experience during peace to reserve components must be expanded and utilized more fully and scientifically than in the past.

Medical training facilities of all elements of the armed forces should be utilized jointly wherever possible. Caution, however, must be exercised in any general implication that the duties of medical officers especially are similar in the three services. Only in those particular fields of preventive medicine and in the actual care of the sick and injured can their duties be held similar. Thus, training must be provided separately by each of the three services for their personnel in all specialized fields demanded by the mission of the particular armed force. There can be considerable economy in war practiced especially in the enlisted specialist categories by joint usage of training facilities. The enigma of administrative system differences between the various services which are

RESTRICTED

RESTRICTED

beyond the control of the Medical Departments must be always considered in plans for the major joint use of facilities in any field.

The terrific wastage of trained enlisted medical specialists overseas by the Army during war should never be countenanced again. Many hundreds of these Army trained specialists technicians were diverted to other services and arms on and before their arrival overseas, by personnel authorities who controlled the flow of all replacements. Most of these malassignments were charged to exigencies of the service by those responsible for such action. The high caliber of these technicians made them especially desirable for any type of clerical or other duty where intelligence and general educational qualifications were most desirable. The necessity for establishing specialist schools overseas in all theaters by agencies ill-equipped and fully engaged in duties in prosecution of combat medical service for these technicians resulted from this nefarious practice. Surety by regulation that the Medical Department of the Army and Air Forces will retain all men whom they have trained under their control must be sought, if we are not to waste time and effort in this field in the future.

The deliberations of this Subcommittee have brought the startling realization that one of the most glaring deficiencies in discharging our peacetime responsibilities is the lack of an agency to keep our profession up-to-date in our specialized field of military medicine. There is a primary and most important need for some form of institution of joint civilian and service composition which will assemble, decide, publish, and in all other ways be qualified to inform all medical men of the best and latest developments in the fields of military medicine and surgery, preventive medicine, atomic medicine, biological warfare possibilities, etc. Our service efforts in recording the results of our research in all fields are woefully uncoordinated and are not available in usable form for the continuing instruction of the medical fraternity. All the medical services are proceeding in divergent paths in the publication of recent advances even in the strictly professional fields. This suggestion when posed before a considerable number of qualified witnesses had broad and full support in the soundness of its concept. It is believed that the high type personnel and facilities for such an institution are currently available and that further study of details of composition, administration and operation and scope of mission of this proposed agency should receive high priority consideration by the main committee of Medical and Hospital Services.

A commonly overlooked but most important factor in planning for training of all categories of medical personnel during mobilization is the supply of competent instructors. In the last two mobilizations insufficient early effort was made to provide the means for meeting this essential requirement. Without competent instructors being available prior to the induction of large increments of manpower, serious wastage of time will ensue. It is the first step in any wartime training program. This connotes the

RESTRICTED

RESTRICTED

absolute necessity for planning NOW for formal intensified training courses at selected service schools for this corps of specialists.

Concept regarding the medical requirements of future wars lead to the realization that the medical requirements of the past will be greatly increased. With a shortage of doctors surely facing us in the event of a national emergency of total war, we must see that the nurses and all other medical categories including enlisted specialists, are trained to do things medically which we now consider wholly within the realm of the doctor. This training must be part and parcel of their basic training rather than specialized for selected individuals.

II. ELEMENTS OF THE PROBLEM

1. Categories of Personnel

a. Enlisted

(1) Basic Training

The systems used for accomplishing this training during the period 1941-1945 by all the services proved eminently successful and plans for future national mobilizations should be patterned after those systems. The length of this training will always have to be adjusted to the demands for the output which in turn depends upon situations beyond the control of the medical departments. Different systems for this training obtained in the Army and Navy during World War II. The Navy enlisted men first received "boot" training at non-medically controlled training centers. Later they were sent to medical training facilities. Army enlisted men received both their basic military and basic medical training simultaneously at large replacement training centers at times under the direct control of the Surgeon General. Both systems proved efficient for meeting the different needs of the services. In general, the basic medical training given by the Navy consumed twice as much time as for that type of training conducted by the Army. The demands of the Army for medical service in its rapid mobilization determined the length of the training periods rather than the desires of the Surgeon General for better and fully trained medical men.

(2) Specialized Training

Realization of the paucity of qualified technicians in comparable civilian skills forced the establishment early in World War II of schools for enlisted specialist technicians. Their value has been universally asserted. There is no indication at present that the same system of training must not again be used in the future. Pre-induction classification of the medical skills under Selective Service machinery will, if established, alleviate to some degree the wastage of skilled technicians by improper assignment. Specialist schools for the essential categories of technicians are currently being operated for peacetime needs by the Army, Navy and Air Force. There is a diversity of the length of courses for similar skills

RESTRICTED

RESTRICTED

in the Army and Navy. The present unsatisfactory enlistment rate in the Army precludes the adoption of the Navy type of specialist training. This factor tends to prevent joint use of present training facilities for these categories. The expansion of these facilities plus the necessary additional ones best located in conjunction with medical centers should be the basis for the wartime needs in these categories.

b. Officers.

1. Medical-Dental-Veterinary and MSG Specialist Corps.

(a) Military training.

No subject has elicited more universal agreement for its necessity for all officers immediately upon their entry into uniform, or more diversity of opinion as to the proper context as to the proper context and lengths of the course that should be given. However, the majority of opinion favors a short intensive course of approximately two weeks duration in which the broad essentials of the military fields, each befitting the particular service, are stressed. Under present limitations essential instruction in medical military aviation fields must be included in these courses. The majority are in favor of giving this training at medical training centers of the Army, Navy and of the Air Force as may be developed later, principally because these facilities are equipped to start courses each week. These centers are equipped to process newly appointed officers with dispatch. Their connection with officer replacement pools proved advantageous to the Surgeon General when trained at these centers. Because of the wide variance in the military feature requirements of the Army, Navy and Air Force, it is not considered possible to utilize joint facilities for this type of training. Those individuals with prior service should be exempt from this training.

(b) Specialist Training

The non-availability of scarce category specialists for field service needs in World War II forced the establishment of special provisions and facilities for graduate training in several of the specialties. All agreed that the courses given were too short in most fields. The urgency in service requirements dictated the length of these courses. There is no hope for betterment in the future. The net result did provide improvement in the practice of the specialties especially where further practical training could be given individuals under constant supervision at large medical facilities. Civilian teaching institutions cooperated admirably in this effort. There was no coordinated effort between the Army and Navy in this field which undoubtedly resulted in wastage. This matter must be coordinated in joint planning for the future. The field of psychosomatic medicine poses a difficult problem. War experience indicated a tremendous need for better training of all doctors in this field. It should not be considered a specialty field in the military organization for war. Continuing efforts, however, are indicated to stress the necessity of broadening of teaching in this subject to undergraduates and graduates prior to their entry into service.

RESTRICTED

RESTRICTED

2. Medical Service Corps

Except for some individuals in the specialist branch of this Corps who will be commissioned direct from civilian life because of their specialty qualifications the officer candidate school system used during World War II by the Army, proved an excellent one for the expansion and development of this Corps. The democratic system of selecting candidates for these schools by competitive methods proved ideal and should form the basis for any system used for this purpose in the future.

More careful selection of these candidates is indicated in future mobilizations to avoid great wastage of time in the training schools. At one of these approximately 37% of the candidates failed because of lack of basic qualifications. These schools provided excellent military training while providing only the barest essentials of hospital administration. More thorough theoretical training in administrative fields would require a lengthening of these courses. It is felt that on-the-job training within their post-graduate duty assignments proved the better method of developing these officers. The location of these schools in conjunction with medical replacement training centers of the Army proved efficacious and should be continued in plans for the future.

A glaring defect occurred in the direct commissioning of many low-grade non-commissioned officers with prior Medical Department service. This resulted in filling many slots in the Medical Administrative Corps with officers of very limited capacity, while reducing the experienced non-commissioned officer ranks. Further, it prevented the commissioning of better qualified selectees for officer positions.

More rigid requirements for the commission of regular non-commissioned officer medical personnel especially in basic educational and officer qualifications is indicated for the future. The recent development in the Army of an expanded warrant officer category will provide the best field of advancement for these peacetime trained non-commissioned officers during future war.

Another serious defect appeared in the use of the "Quota" system for supplying candidates for officer candidate schools. While training facilities must be kept operating at peak loads by a system of planned allotments of trainees to the field agencies during war, that fact in no sense justifies the forcing of any agency to send numbers instead of quality for training. Graduates of Medical Department officers candidate schools should be prevented from serving in other services or the arms to avoid wastage of Medical effort and resources.

The war requirements for qualified officers in the specialist category branch of the medical service corps were met in most instances by direct commission from civil life. A short course in military indoctrination was all that was necessary to qualify these individuals for their military assignments. A few selected individuals of this corps were given additional professional training after entry into service, at civilian institutions to better

RESTRICTED

RESTRICTED

qualify them in specialized fields. No change is indicated in the service training of this category in future national mobilization.

3. Undergraduate Training

The V-12 and ASIP programs of World War II for providing a continuous supply of practitioners proved sound for both Army and Navy. There has been much discussion regarding the merit and necessity for subsidization of medical students during war to insure the current needs and a reserve for the Armed Forces. There is no indication in the foreseeable future that the supply of doctors will be sufficient to eliminate the need for the resumption of some similar provisions in the event of another war. There was little, if any, coordination between the Army and Navy in their identical programs. This deficiency should be corrected in planning for the future to avoid competition in producing the identical product. The experiences now current in meeting the postwar medical needs emphasizes the need for a change in the process which will demand of each subsidized student a specific term of service upon his graduation. This provision, thoroughly understood by the student at the beginning of his subsidized training, would eliminate to a great extent the disaffection so apparent among such recent graduates called to duty. The fairness of this form of contract cannot be questioned. It should be planned for the future.

4. Nurses

(a) The establishment of the Nursing Corps in the Services is a change from World War II conditions. Each of the services is currently enrolling large numbers of reserves in an attempt to reach its wartime requirements. The establishment of a national registry for nurses will clarify the resource problem as in the case of all other ancillary groups and permit of an equitable allocation of nurses to the using agencies. The Army is being forced to re-establish its school of nursing in order to obtain its peacetime requirements but this action will be of but minor help in meeting war demands. Continuing dependence must obtain on civilian teaching institutions for our wartime requirements.

(b) There is no change indicated in the wartime system used for training of selected nurses in their specialties, at service hospitals, or at Air Force Training Centers for aviation nurses. It produced good results.

(c) All nurses should be given a short course of military indoctrination training of not over one month's duration immediately on their entry into the service. This was done in some measure in conjunction with medical replacement training centers during the war and it should be included in the plans for the same facilities in any future emergency.

(d) It is universally agreed that Nurses Aides are an important factor in the process of saving male manpower in war. This program, which entails the training of women in nursing techniques, can best be conducted in conjunction with the service hospitals. There is no need for change from World War II practices in this field.

RESTRICTED

RESTRICTED

(e) Because of the unique problem of the martial status in the female, the supply of nurse reserve is bound to be a fluctuating one. There can be no legal measures taken to insure stability in this field even with a national registry operative. Hence, wartime training of nurses will be a necessity. The Cadet Nursing Program used in World War II proved effective and should be re-established early in a future war threat to the nation.

(f) The training and procurement of nurses has never been coordinated before in peace or war between the services. Its importance demands it in the future.

5. Medical Women's Service Corps.

(a) The modern developments in medical practice have brought the need for these specialists into major focus. The current peacetime training output from civilian institutions is far below that required for peacetime needs of civilian agencies. The Army had been forced into the establishment of service courses for full training of dieticians and physiotherapists to fill its peacetime needs. As these courses are of long duration, reliance should not be placed on this meager source of wartime needs. The only solution rests in the development of civilian sources of education to furnish an adequate reserve in these categories. The method of stimulating sufficient interest in civil life for these avocations should receive proper study and action to achieve that result.

(b) The military training for members of this Corps should parallel that for nurses and can be given jointly with them.

2. Medical Unit Training.

Undeniably medical units must receive training as a group to accomplish the smoothly operating facility necessary to perform its particular mission. Much time and service was wasted early during World War II in this training because of several factors. Units were activated too early with entire complements of personnel. There was little for the doctors or nurses to learn during this phase of training because of their professional training which could not have been accomplished in a period of not over two weeks. The principal need was for the thorough training of the non-professional individuals of the unit in a group action in the packing, loading, movement, establishment, maintenance and operation of these units from an administrative and equipment standpoint. This can be accomplished with the full complement of non-professional and command personnel with only "key" professional personnel present. This system was developed in the later stages of the war and proved efficient. It should form the basis for planning procedures in future mobilizations.

RESTRICTED

RESTRICTED

3. Medical Staff Planners, etc.

Previous experience indicates the training of this category after war has become a fact, is too late to be of real value. Mistakes are made mostly early in mobilization and during early phases of war, principally because of the incompetence of our medical officers to plan effectively. It is true that time corrected many of these early mistakes because of the training received by hard experience. To accept this insecure method of discharging our peacetime responsibilities is to admit our inability to learn from experience. That there is insufficient effort being made by the services to train selected officers in the advanced phases of this work is conceded by all. World War II demonstrated the unfairness and inefficiency resulting from the lack of a definite pool of this category of medical specialists. These selected officers must be trained with the line and other components in the service and staff schools. The importance of association as classmates of the line in these schools cannot be over-emphasized. It proved to be invaluable to the medical staffs in World War I and II in their positions of high responsibility. The provision for this training must receive the attention it deserves NOW if we are not to fail in our efforts to conserve the national medical resources in future war.

In the face of past experience which will surely be repeated it can be categorically stated that every regular medical officer must receive during the first ten to fifteen years of his career a comprehensive course in the military aspects of his duties on an advanced basis. This can be accomplished at our medical service schools. The Army Gerv plan of training provides this and every effort must be made to carry out its concept and spirit in all of the services if we are to establish the quality of medical leadership essential to a national war effort.

4. Demobilization Training of Medical Officers.

Considerable criticism of the post-war professional training program offered medical officers by the Army has been elicited. The program as conceived was an excellent one and is considered worthy of consideration for study in the future. The general chaos that ensued with the national demand that everyone in uniform be released immediately after V-J Day resulted in the elimination of all order and sense in the demobilization process. This doomed the refresher training program which was offered medical officers. It cannot be divined at this time that the same hysteria will not recur under similar conditions. Plans for the future should include not only the programs for such training, but specific details as to how this training can be given in the face of a recurrence of the conditions which followed V-J Day in World War II. Unless general demobilization plans are adhered to meticulously in the future, little improvement can be expected and previous errors will be repeated. Basically, it must be made mandatory that no promises be made in this field unless it can be definitely assured that proper and adequate facilities are going to be available. Because the process must remain voluntary and the applying for it can only be very indeterminate, extreme caution is essential in promising anything that cannot be adequately planned for.

RESTRICTED

RESTRICTED

III. CONCLUSIONS

The Committee concludes:

- 1. That the emergency training of medical personnel is essential to the success of medical effort in war.**
- 2. That the emergency training given medical personnel in World War II was successful in general and plans for similar training agencies should be adopted for future mobilization training.**
- 3. That indoctrination medical-military training of all officers of the medical services, including nurses, Women's Medical Service Corps and selected members of the medical service corps is necessary immediately following their entry into the services. That the training period should be as short as possible and not exceeding four weeks. That officers with previous military training and those for specialist assignment in specific fields should be excluded from this training.**
- 4. That training an adequate supply of instructors must precede efforts to train the masses. That this is best accomplished by training of regulars for these duties during peace.**
- 5. That there is need for better training of all medical officers in the fields of psychosomatic and physical medicine and in the medical aspects of atomic and biological warfare. That this training should be stimulated during these peace years in civilian teaching institutions.**
- 6. That the officer candidate school system was an ideal method for the selection and training of members of the Medical Service Corps and should be readopted in plans for the future.**
- 7. That every method for improving the peacetime training of medical reserve components should be explored and developed. That peacetime training of reserves will reduce the post-induction training periods, especially in the purely military sphere.**
- 8. That joint use, wherever practicable, of all medical-military training facilities in peace and war is indicated in the interests of economy and should be developed fully in planning for emergencies.**
- 9. That the V-12 and ASEP programs for training undergraduates proved sound. That they should be combined as a joint National Defense Establishment activity in future war. That provisions for a definite period of post-war service, if it is required, say five years, should be written into the law to prevent disaffection.**
- 10. That medical units require training as such prior to their use.**
- 11. That short courses of training for officers after entry into the service in the specialty fields will be necessary in the future in the scarce categories. That similar methods utilized in World War II should be planned**

RESTRICTED

RESTRICTED

for the future. That more care must be exercised in the assignment of graduates of these courses in the future. That this feature can be accomplished by better planning.

12. That medically trained enlisted technicians were wasted in overseas theaters by staff and command interference, principally in replacement depots. That to avoid this, the Chief Surgeon must be authorized to control all medical personnel arriving as replacements in overseas theaters.

13. That much of the success of the service medical effort in war is dependent upon the quality and training of medical officers assigned staff and command positions. That this field constitutes a specialty. That it is essential sufficient importance is given the training of these specialists during peace. That it cannot be accomplished in war as an emergency measure.

14. That service schools for physiotherapists and dieticians will be necessary to provide the requirements for service needs in war. That provisions for the joint use of these facilities which must be greatly expanded in emergency is indicated.

15. That the Nurses Aide program and the Cadet system for training nurses were necessary and successful in World War II. That they should be re-established in future emergencies.

16. That the creation of a permanent joint service institution for the collection, evaluation, publication and dissemination of past, current and future research and development in the fields of military and naval medicine and surgery, preventive medicine, medical aspects of atomic and biological warfare, is a prime necessity of the moment for the peacetime and emergency training of all medical personnel, civilian and service.

That highly trained civilian and service personnel are indicated to comprise the faculty of this institution.

That accommodations are considered available within present facilities of the services for this institution.

That resident, extension and special courses are feasible under this concept.

17. That because of the extreme specialized nature of all medical training full control of all medical training facilities in war be vested in the Surgeon Generals of the respective services.

IV. RECOMMENDATIONS

The Subcommittee recommends the following:

1. The immediate creation of a permanent joint service medical institution as described in the body of this report and in Conclusion No. 16.

RESTRICTED

RESTRICTED

Active pursuance of every possible effort especially with civilian medicine to advance the training of civilian practitioners during peace to better equip them for services in the event of war.

2. The inclusion in the specific plans for training of medical personnel for future emergencies of the training facilities and methods used by the services during World War II, with the necessary indicated minor improvements especially in the indoctrination field of newly joined officers.

3. Staff action to insure full control of all medical replacements by the Chief Surgeon in any area to eliminate the serious misassignment of medically trained technicians that occurred in World War II in replacement depot practices and thus prevent the wastage of training effort and scarce category medical skills.

4. Constant and intimate liaison between Medical Departments of the services with their general staff agencies which are now planning for emergency training in future mobilizations.

5. Adequate provisions be made immediately to train selected regular medical officers during peace for a career specialty in staff and high command assignment in war.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Brig. General Roy C. Heflebower, USA (Ret.)
dated (undated) - received 30 April 1948)

**** 9. I am also of the opinion that all Medical Department enlisted personnel should receive their basic training in Medical Replacement Training Centers. During the recent war the Ground Forces desired to train their own personnel, and in the case of the Divisions which were trained at Camp Barkley, Texas, the training of Medical Department personnel in these Divisions was certainly not to be compared with that received in the Training Center. In fact, the Training Center cooperated with some of the Division surgeons and trained both officers and men for them. In my opinion basic training should be conducted by the Medical Department and then unit training should be conducted by the unit to which the men are ultimately assigned.

10. The experience with the Medical Administrative Corps Officer Candidate School shows a faulty method of selection of candidates, and it is believed that this was common to other officer candidate schools. Eighteen thousand nine hundred ninety-eight (18,998) candidates were enrolled in the school but twelve thousand four hundred eight (12,408), or 65.3 per cent graduated and were commissioned. Seven hundred seventy-five (775), or 4.1 per cent, were found deficient academically; one thousand five hundred ninety-three (1,593), or 8.4 per cent, were relieved because of lack of leadership; one hundred fifty-nine (159), or 0.8 per cent were physically disqualified; and three thousand three hundred fifty-nine (3,359), or 17.7 per cent were relieved at their own request. How this situation can be corrected is a problem. In my opinion the quota system is to some extent at least responsible. Commanders are told that they must send a certain number of men to an officer candidate school, and these quotas are filled regardless of the fact that the men sent are not officer material. It was very noticeable that a much higher percentage of successful candidates came from Medical Department Replacement Training Centers where special courses of instruction for potential candidates were conducted. This leads to the conclusion that preliminary courses of instruction for officer candidates for the schools of all branches might be conducted in the various Service Commands and thus serve to eliminate many of the applicants which would otherwise be sent to the Officer Candidate Schools only to be relieved later because of undesirability. Such a method would not only save time and money, but would undoubtedly result in obtaining better officer material. ****

16. Generally, I feel that the training program for officers, officer candidates and enlisted men was well considered, efficiently inclusive, and produced excellent results. This opinion is based on my own observation and also on statements made to me by these officers have invariably been to the effect that the officers and enlisted personnel trained at Camp were generally of very high caliber.

RESTRICTED

RESTRICTED

17. It is also suggested, when training programs for officers are to be conducted in Replacement Pools in the Zone of the Interior, that these pools be located in replacement training centers. In the latter, training is being conducted in all of its phases at any particular time due to the fact that the beginning of training periods is staggered. By utilizing classes of instruction going on in the Center, it is possible to start the instruction of an individual officer immediately upon his reporting to the Replacement Pool. This saves much time, as the new arrival does not have to lose time while waiting for the start of a new class as would be the case outside of the Training Center.*****

L. K. Pehl

L. K. Pehl, Colonel, MG

RESTRICTED

RECORDED

109

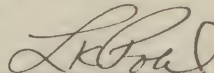
RESTRICTED

TRUE EXTRACT COPY

(Letter from Capt. Warwick T. Brown, (MC), USN
dated 20 April 1948)

***** "b. Professional and military emergency training programs within the Armed Forces.

From the standpoint of amphibious and field medicine, military training for medical officers is essential to the advantageous utilization of their services during war. Many of the deficiencies of the last war in the functioning of the medical forces were due to the lack of medical officers with military training. The training objectives should be (1) to train a selected small group of medical officers in military tactics, techniques, and staff procedures and (2) to familiarize a larger group with the field or amphibious medical organization, equipment and functions. Training facilities should be available at an early date as mobilization is always hurried and much valuable time is lost in setting up the training facilities. In World War II the number of medical officers trained in line staff schools were not sufficient to supply the need for Lieutenant Commanders and Commanders of the Medical Corps capable of functioning in medical staff sections, as Medical Battalion Commanders and as Division Surgeons. It is recommended that a certain number of medical officers in the Lieutenant Commander and Commander grades be assigned to the senior course in Amphibious Warfare at The Marine Corps Schools. It is also recommended that schools for training in field medicine be organized at Camp Lejeune, North Carolina, and Camp Pendleton, California. These schools to be utilized for training medical officers and medical department petty officers in the functions, equipment and organization of field and amphibious medicine. In this connection it is recommended that the opportunity for both types of training be also offered to certain selected reserves during peace time. *****



L. K. Pohl
Colonel, U. S. Army

RECORDED

RESTRICTED

RESTRICTED

TRUE COPY(Extract Ltr Quinton M. Sanger, BUMED, USN, 7 April 1948)

****"The liaison between the Bureau of Medicine and Surgery and the War Plans Section of the Navy Department was inadequate. "During World War II the lack of early and adequate information regarding strategic requirements led to erroneous estimates of material requirements and resulted in numerous embarrassing and emergency situations." Admiral King did not accept a full time assigned medical officer as a member of his war plans staff.

To effectively support the operating forces, the Medical Department needs to know better the type of war and combat operations the operating forces expect to conduct in a possible future war. The location, size and type of medical installations can then be systematically planned, but not without this knowledge.

CNO felt liaison was adequate, but was hampered by the need to maintain secrecy for information that really required widespread dissemination.

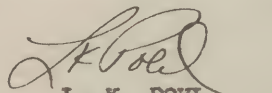
During the war the Medical Department had to depend on the reserve medical officers. This individual was often an excellent clinician but had no experience or training in handling large groups of men or problems which arose when hundreds of men attended sick call.

The interest of these reserve medical officers should be stimulated during peace time so that they will be willing to take necessary indoctrination work in leadership and in medical problems peculiar to a wartime Navy.

It was claimed that medical officers were not sufficiently trained in what material is required to accomplish a specific mission.

It was proposed that the Naval War College should instruct medical officers on the medical problems which arise in connection with the general war problem that the War College is carrying on.

Reserve medical officers complained to Congress that they were in many cases not ordered to post graduate training courses which had been promised them." ****

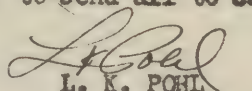

L. K. POHL
Colonel, MC

RECEIVED
RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr James E. Hix, Lt Col., MC, (Resigned) 11 April 1948)

*****I believe that the Regular Corps should be so constituted that periodic professional training is available for those desiring. To eventually successfully achieve this, there will have to be an increase in personnel--which I know is a problem. Most doctors can be trained very quickly for military service. It is by no means necessary to send all to Carlisle for 1 month.*****

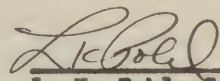

L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Brig. Gen. Robert C. McDonald, MC, USA (Ret.)
dated 15 April 1948)

***** "(b) Professional and Military Emergency Training Program within the Armed Forces.

"(1) Comment: Professional training of medical specialists in W.W. II lagged behind requirements. Courses were too short, while on the other hand, military emergency training was more than adequate for many medical specialists.

"(2) Suggestions: Medical specialists should be called into Service far enough ahead to allow time for adequate special training in civilian and military installations prior to assignment. Military training of medical manpower, both basic and technical, should be conducted at Armed Forces Medical Training Centers." *****


L. K. Pohl, Colonel, MC

RECORDER

RESTRICTED

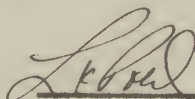
RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert K. Simpson, USA (Ret.)
dated 1 May 1948)

***** (b) Professional and military emergency training programs within the Armed Forces. Special emphasis on field training, sanitation, hygiene, evacuation, field hospital operation for those not specially interested in any of the specialties; refresher postgraduate courses at military, or civilian, institutions for those with specialized training, or those apt and interested in one of the specialties.*****

TRUE COPY EXTRACT (Letter, Col Robert P. Williams, MC, Surgeon, 16 Apr 48)

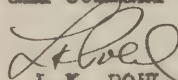
***** (b) "Professional and military emergency training programs within the Armed Forces. Purely military training: drill, customs, courtesies, uniform regulations, etc., to be given in a short intensive course of two to six weeks." *****



L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Ltr Capt E.R.Hering(MC)USN, dtd 17 Dec 47)

*****B. "Lack of understanding of the basic need for sanitation and preventive medicine in the field. Early in the war it became apparent that the doctrine of securing labor for major sanitary projects from the fighting troops themselves was unsound. Various expedients were tried, including the order assigning additional men to Construction Battalions to work directly under the medical department. On the one operation (Okinawa) when I observed this system, these personnel were never available either for training or field operations as they were urgently needed for their primary function of building roads and airports. The formation and assignment of the Malaria and Epidemic Control units was a master step in the proper direction but without personnel to actually carry out their directives, the preventive medicine program fell short of its goal in the field. A training course for Medical Officers in Amphibious and Field Medicine should be established in much the same manner as courses in other medical specialties. By so doing we could assure ourselves of a nucleus of trained officers and actually decrease the number of medical officers assigned to Marine Corps Forces on a year around basis. By assigning medical officers for a two month course as recommended in enclosure A, we could give adequate medical service when it is needed and confine our activities to purely medical matters for the rest of the year. After preliminary training, such officers showing an aptitude for this specialty could be assigned to various staff and command schools for advanced training."*****



L.K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

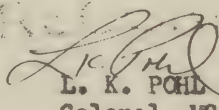
TRUE COPY (Extract Ltr Quinton M. Sanger, BUMED, USN, 15 April 1948)

****"It was suggested that BuMed's Professional Services Division be responsible for medical training programs, for the initial assignment and periodic evaluation of medical officers; and that assignment, transfer and promotion should be made only in consultation with or on recommendation from this division.

A generous policy permitting attendance of medical officers at meetings of recognized civilian clinical organizations should be instituted. This was proposed in part as a way of keeping the good will of civilian medicine.

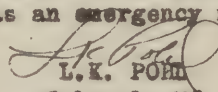
The complaint was made that Navy nurses spend too much time instructing corpsmen, and in administrative or clerical work, and not enough in bedside nursing. Waves were recommended for the administrative work, and special instructors were suggested to train corpsmen.

It was proposed selected members of the Nurse Corps should be permitted to obtain post-graduate training in special nursing fields at selected civilian or other hospitals. Nurse training after entrance into the Navy was criticized as weak during the war."****


L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Ltr Brig Gen Guy B. Denit, MC, Surgeon, dated 13 Apr 48)

***** Professional and military emergency training programs within the Armed Forces - The military training program as conducted at the Medical Field Service School at Carlisle Barracks was in my opinion of inestimable value to all who received training there. Likewise the professional training program in the various schools throughout the country were of great value. It is possible that this program can and should be improved upon but as an emergency measure it was very effective."*****


L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Ltr Rear Adm F.L. Conklin (MC) USN, 27 Apr 48)

***** B. "All Reserve Medical Officers should receive peacetime training, either on an active duty status, or by a correspondence course. By calling Reserve Medical Officers to active duty, their services can be utilized, even though in a training status. By so doing, their professional qualifications can be better judged."*****

RESTRICTED

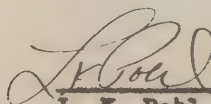

L. K. POHL, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M. J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

**** "(b) Professional and military emergency training programs within the Armed Forces.

Under the category it is my sincere belief that the training programs in force at the out-break of World War II were excellent in type and reflected great credit upon those who had created them. This, of course, represents a most favorable reflection upon the quality and standards of our medical profession. Insofar as the efforts of the military establishments are concerned in this respect, here also do I consider that these several programs were of a high quality. I believe that the medical services of our army and navy in this late war met their responsibilities in an outstanding manner and fully and completely answered every call of duty. I do not know of any single instance where there was a failure of the medical services to function in the highest degree and in keeping with the highest possible standards. Our medical services were ready, we were prepared. Certainly this was true at Pearl Harbor and thereafter during my experience in the Pacific. I am not competent to compare the training programs employed in the army with those of the navy. The success of our V-12 program has been well demonstrated and it would seem to me that a program of this sort could well be utilized in the future. A consideration of our present professional training programs might be in order here. I refer specifically to such programs that are now provided and which will result in higher standards of medical education and training. Many of our young doctors are receiving Residency Training and special courses which in due time would lead to certification by various specialty boards. Certainly the individual benefits greatly by such training and the standards of our medical corps are thus enhanced. It is to be hoped that our services will be benefited permanently by such professional training programs. We should expect to retain in the services, most if not all of such trainees inasmuch as such programs should be expected to confer lasting benefit upon the medical corps as well as the individuals concerned. Our medical corps exists primarily to serve the needs of our naval establishment. Over-emphasis in any training program should be avoided. In other words, "The tail should not wag the dog." ****



L. E. Pohl, Colonel, MC

RESTRICTED

(b)

RESTRICTED

TRUE COPY EXTRACT (Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 29 March 1948)


***** "(11) I think we ought to make a strenuous effort to indoctrinate all of our medical officers with the concept at least of psychosomatic medicine and some orientation as to what to do about the functional physical complaints that compose twenty to forty percent of our gastrointestinal, cardiac and orthopedic wards."*****



L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Ltr fr N. C. Washburn, Colonel, MC, AF, 19 April 1948)

*****"During the critical time of expansion in World War II, medical administrators were the big problem. Specialists were available from civilian sources. Recommend the training of medical administrators not be overlooked."*****



L. K. POHL
Colonel, MC

RESTRICTED

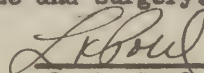
RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT HISTORICAL RECORDS OF WORLD WAR II. (1st Bombardment Division 44)

***** "In connection with the problem of medical personnel are the factors of professional staleness, waning interest and morale, and the tendency to become self-satisfied in a smoothly working organization. Various means were utilized and initiated to combat these, particularly in the doctors who have served overseas the longest. Higher echelon instituted various research problems in aviation medicine. These will be discussed in their proper medical category. (Higher echelon also made possible detached service at various station and general hospitals in professional capacities. These brush up periods were extremely valuable to Medical Officers who were anxious to bring themselves up to date on the newer aspects of more definitive care of the sick can be accomplished in a small sick-quarters). For rest, relaxation and change of scene, the Surgeon, Eighth Air Force, has allotted this Division several of the Air Force Rest Homes to cover medically. Each week, one of our Squadron or Group Surgeons has been sent for a tour of duty at the allotted rest homes. Other medical officers and enlisted men were sent in teams, to various RAF airdromes near the south and east coast of England. 1st Division Bombers, when returning from a mission, would occasionally come into these dromes in an emergency, and the personnel on detached service supplied medical emergency care of the casualties. (Appendix A) Another method of supplying the medical officer's need for professional change and stimulation was a system initiated by the Division Surgeon for exchange detached service with several RAF combat and training fields. Our medical officer would put in a weeks' service at the RAF station actually working and filling a job there. Thus he would be able to observe and appreciate the RAF methods for handling sick and injured flyers. The comparisons afforded the Flight Surgeons while on this service helped to establish a better perspective in the care of their own flyers when they returned. Most of our Flight Surgeons who participated in this exchange, favored the RAF combat stations. These exchanges were stopped shortly before 'D' Day. Still further professional stimulation was afforded our various Flight Surgeons by attendance at and participation in frequent medical meetings of the station hospitals serving the area." *****

(Medical History, 1st Bombardment Division - 1942-43)

"The inherent nature of the Flight Surgeon's work is such as to remove him from the sphere of hospital medicine and methods. The need for keeping Flight Surgeons informed and trained in advances in this type of care was recognized early by higher echelons in the Eighth Air Force, and to supply it they arranged for the squadron and group surgeons to attend various short courses in both military and general medicine and surgery." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel James H. Forsee, MC, USA, 20 April 1948)

***** "(B) The Professional and Military Emergency Training Program Within the Armed Forces.

1. A large active Medical Reserve Corps training program would appreciably aid in the solution of this problem. Preparatory measures are the only means of adequate training in the advent of the presumably atomic type of warfare.
2. Time seems to be such a tremendous factor in the anticipated warfare that emergency training programs for doctors, nurses, etc. may be almost impossible of accomplishment. Teaching in medical, dental and nursing schools, at the undergraduate level plus training in Service Schools and Hospitals appears to be the most feasible plan. In view of these statements the following is recommended.

The establishment in our teaching hospitals of the Army and Navy prescribed courses of instruction for reserve officers and civilian doctors in professional matters pertaining to War Surgery, Medicine, Preventive Medicine, etc. These courses should be of at least of one (1) months duration. No institution should be better able to teach these subjects than military hospitals. Recognition from professional channels will be readily forthcoming if the instruction is good." *****

RECORDER

L. E. Forsee

L. E. FORSEE, Colonel, MC

RESTRICTED

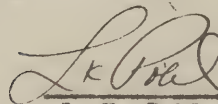
RESTRICTEDTRUE COPY EXTRACT(Letter, Captain O. B. Morrison, Jr., MC, USN
dated 23 April 1948)

***** "b. Professional and military emergency training programs within the armed forces.

Short courses of instruction and practical training should be offered to volunteer reserve groups to keep them up-to-date in the art and science of warfare. The armed forces must have at least a well-trained nucleus, so that in time of national emergency, additional medical officers can be instructed in such subjects as aviation medicine, submarine medicine, atomic bacteriological and gas warfare."****

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus (MC) USN dated
27 April 1948)

***** "(b) It is considered that intensive military emergency training programs should be afforded all medical personnel as soon as possible after mobilization in order that through indoctrination and special instruction they will be prepared to carry out their duties in the field. Numerical assignments without consideration as to qualifications may be wasteful of manpower and effectiveness of service performed. Many of the special training courses that were organized and carried out during World War II paid real dividends and contributed greatly to the effective conduct of subsequent operations." *****



 L. K. Pohl, Colonel, MC
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C.B. Camerer (MC), U.S.N.,
Retired dated 21 April 1948)

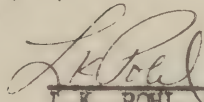
**** "Along the general lines approved and followed during the progress of World War II, amplifying essential Military Medical training in Service Schools and Hospitals PRIOR to assignment to active "front line" duties of whatever nature. It appears that the establishment and maintenance of full time Service Medical Schools becomes imperative in order to obtain uniform teaching and indoctrination of medical students who are prospective candidates for future commissions as Service Medical Officers." ****

TRUE COPY EXTRACT (Letter, T. F. Cooper, USN, dated 19 April 1948)

***** "In the interest of a medical military and naval arm, special courses in military and naval medicine should be established in all medical schools. Taking the course should be obligatory. Officers teaching the courses should be specially picked regular officers of the Medical Corps whose business would be not only to teach but to recruit. The course would lead to a regular or reserve commission for those physically qualified. The job could be combined with regular recruiting in the large centers and would at the same time offer opportunity for postgraduate training of the instructors.

"I believe the present training program to be excellent and hope that it can be maintained and expanded. It will soon be seen that opportunity for self-improvement is far greater in the service than is possible in the practice of medicine as a civilian. Medical men will be attracted to the service by the high level of medical competence that will obtain.

"Internships should be lengthened and all medical officers, regardless of specialty, should receive sufficient surgical training to perform traumatic and emergency surgery with a degree of self-assurance that is comforting to the patient, when confronted with such problems at sea or in isolated areas." *****


L.R. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr Alfred W. Eyer, Captain (MC), USN, 17 April 1948)

**** * (b) Professional and emergency military training programs within the
Armed Forces.

"I comment on this question with a great deal of hesitation due chiefly to a rather limited and narrow experience with Naval medical service personnel in the field and little contact with thinking on service policy making levels.

"However, it appears to me that entirely too much emphasis is being placed upon professional specialization in the medical service of the U. S. Navy. Basically, in the past, the Naval Surgeon has been an individual with diversified training which adapted him peculiarly to the needs and requirements of the Naval Service in peace and war. Further, it tended to develop confidence and ability to meet normal and emergency situations in individuals; and, what is more to the point, a sense of responsibility and the willingness to accept such responsibility in connection with their duties.

"I do not find such attributes emphasized in the present day. It appears rather that the mass of medical personnel are being encouraged, at an early stage of their career, to seek specialization in a particular branch of medicine. This policy, even though predicated on a basis of urgency, is considered fallacious and detrimental to the best interests of the service.

"The young man who may be favored by the circumstance of selection brings up a number of problems:

"If permitted to maintain professional proficiency and excellence in his chosen specialty by selective assignments, his relative value for general assignment requiring broad experience is greatly diminished.

"If the individual is not given selective assignments which tend to reinforce his specialty qualification, discontent is invariable.

"It is inconceivable that all medical personnel can be trained and become specialists in the accepted sense. This gives rise to considerable discontent among those not fortunate enough to be selected.

"There is no question regarding the value of the specialist in his particular field. However, it is felt that service needs in wartime should be filled from civilian categories. In peacetime, emphasis toward specialization should be directed toward service functional utilization in the branches which require particular technical appreciation of the problems involved.

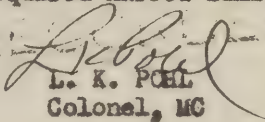
"All civilian medical men prior to or upon being inducted into the Service should have a short indoctrination period. This period should include information on medical service organization, functioning, procedures and a broad picture of service needs. Much discontent among medical personnel was encountered during the last war because of lack of understanding among those who had made a rapid change from their peacetime pursuit to an unfamiliar working environment.

RESTRICTED

RESTRICTED

[Extract from Ltr Alfred W. Eyer, Captain (MC), USN, 17 April 1948, cont'd)

"Wherever practicable, short refresher courses in service hospitals should be given to personnel returning from sea or foreign shore billets. This would tend to maintain professional standards and capability among those personnel whose duties required narrow limits of professional service."


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Nellie Jane DeWitt, Captain (MC) USN, 29 April 1948)

*****INDOCTRINATION AND DISTRIBUTION


Indoctrination centers should be established at large hospitals in certain areas, such as - Bethesda, Great Lakes, Mare Island, Oakland, San Diego, and Portsmouth, Virginia.

- (a) These centers should be permanently staffed with personnel especially adapted to and trained for this assignment.
- (b) These centers should act as pools both within and beyond the continental limits.
- (c) Ship's Service stores at these centers should be prepared to supply all necessary uniform equipment.

The training period for indoctrinees should cover four to eight weeks and should be followed by duty in the center giving the training, and should provide a total of not less than six months before assignment in another activity is permitted.

During the training of these indoctrinees the importance of military nursing should be stressed, and they should be instructed thoroughly in the handling of service personnel, and in methods of planning and organizing their details, so as to require the least possible expenditure of time and energy.

Indoctrinees should be required to familiarize themselves with military customs, courtesies, drill, and should learn to swim.*****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

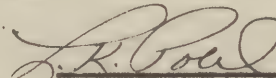
TRUE COPY EXTRACT (Letter, Captain H. D. Templeton, MC, USN
dated 23 April 1948)

******* (B) PROFESSIONAL AND MILITARY EMERGENCY TRAINING ORGANIZATIONS
WITHIN THE ARMED FORCES.**

The training of medical personnel to cope with all types of military emergencies received much attention during the past war, and it would be highly unfair to criticize a method of training that proved so effective in reducing the mortality rate of our wounded.*****

TRUE COPY EXTRACT (Letter, Captain J. H. Robbins, (MC) USN dated
26 April 1948)

**** "Recommendations: It would appear that the majority of these complaints could have been avoided if our Bureau could have in some manner prior to the opening of hostilities, informed all physicians of what the exigencies of the service might expect from them and had some policy laid down for their rotation of duty."



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel O. F. McIlroy, MC, Air Force
dated 20 April 1948)

***** "b. Professional personnel should be required to participate in only a minimum amount of military training. Professional training should be as extensive as possible to the point of diminishing returns and dependent upon available time and personnel." *****

TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee, dated 18 April 1948)

***** "(b) Professional and military emergency training programs within the Armed Forces.

"The so-called 'officers' training courses' insofar as they applied to medical officers were almost 100% wasted effort. All the strictly military matter which a medical officer should be called upon to know could be gotten from an intelligently written manual in a few hours. Professional training courses were eagerly sought by medical officers bored to madness by inactivity, but with the exception of the tropical disease courses and the aviation medical examiners' courses they were largely useless. The stupid malassignments of medical officers who had attended special schools were so numerous as to appear deliberate. Medical schools should be asked to give a certain amount of military medicine of an 'indoctrination' kind as part of the course and largely eliminate such training for doctors already mobilized." *****

RECORDED

L. K. Pohl
L. K. Pohl, Colonel, MC

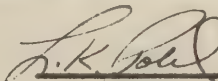
RESTRICTED

(b)

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Robert M. Gillett, (MC) USN
dated 15 April 1948)

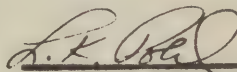
***** "The present shortage of personnel within the armed forces
makes the emergency training program highly impracticable at this
time." *****



L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Dr. A. R. Shands, Jr. dated 20 April
1948)

***** "The training programs were certainly quite adequate." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel F. A. Blesse, MC, USA dated 19 April 1948)

*****2. Professional and military emergency training programs within the Armed Forces.


"a. As a policy, peacetime training of reserve officers should be limited to medico-military training. The short time available for training of reserve officers must be used to adjust his professional knowledge to the requirements of the military service. His professional training is a personal, civilian responsibility and goes on constantly during his career as a practicing physician.

"b. Specialists should be divided into age brackets, in addition to their classification according to proficiency. Those assigned to the active theater of operations, and especially those assigned to Evacuation Hospitals, Surgical Hospitals and cellular teams (8-500 series), should be in the younger age bracket.

"c. Medical officers of the regular army who have fully qualified in one of the specialties should be kept on such assignments during war as well as during peacetime. To relieve such officers from their assignments as professional specialist in time of war, seriously retards their progress and reduces the efficiency of the Medical Corps in the post-war period. Their assignment as unit commanders etc, places them in positions for which they are totally untrained and reduces efficiency.

"d. The individual training of certified specialists, whose duties in the army will be identical with those performed in civilian practice, should be omitted, except for training within the unit to which assigned. Such specialists should be ordered directly to their units for duty and training should be in addition to their normal duties. In making such concessions, however, consideration should be given to the fact that most of the criticism concerning misuse of medical officers is due to a lack of understanding by the individual of military organization, functions, missions, tactics and over-all problems. Such criticism is most frequent among untrained officers.

"e. The Army Specialized Training Program and the Navy V 12 Training Program for the undergraduate training of candidates leading to the M. D. degree, should have been coordinated. One program should have been adopted and the output proportioned according to the requirements of the Armed Services.



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT - Continued - Colonel F. A. Blesse, MC, USA

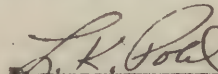
"f. Professional training of medical officers during a period of emergency, should be conducted at installations best equipped for such training and standardized to meet the requirements of all the Armed Services. Consideration should be given to location to avoid unnecessary loss of time and travel funds. The length of courses should be coordinated with the training time available for long periods of preparation will not be possible in an accelerated mobilization training.

"g. The technical training of enlisted men should also be standardized by the Army and Navy. Since there is no difference between sick or wounded men whether Army, Navy or Air Force, this would appear feasible. Thorough basic training should, however, always precede technical training.

"h. Military training of officers of the Medical Department can also be best accomplished at a center, or centers, such as the Field Service School. All officers, except qualified specialists and those with recent, prior service, should be given a thorough course of basic training prior to assignment. This training should be coordinated with the Office, Chief Army Field Forces.

"i. The broad mission of the Medical Department is to maintain the fighting strength of our troops and this involves numerous responsibilities. There is a growing tendency to concentrate on professional training and to neglect the others which are equally important in the final accomplishment of our objective as expressed in the broad mission. Officers are assigned to command of hospitals and other similar units or higher staffs, without any training for such responsibility. The qualities of leadership, and ability to properly command and deal with the many administrative problems of a unit, must be developed by training. If command of medical units is to remain as a function of the Medical Department, then we must provide for their systematic training so as to meet all the responsibilities implied in our mission. The selection of medical officers for other than purely professional assignments must be given the same thought as the selection of other specialists, and they must be assigned to such duties for practical training. A medical professional background is essential for such assignments. It must be understood that this does not constitute a misuse of doctors, unless we are willing to release all command, staff and administrative responsibility and restrict ourselves to professional care of patients only. This would no doubt result in a question as to the need for the Medical Corps as a part of the Army and place medical service on a contract basis. Many medical officers who have demonstrated special ability and interest in this field of work, have requested and been transferred for training in a professional specialty because of a feeling of loss of prestige resulting from such other assignments. This must be overcome or the accomplishment of the broad mission of the Medical Department will fail. Career planning of Medical officers must be primarily based on the needs of the Medical Corps and not on the individual desires of each individual.

RESTRICTED



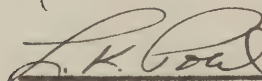
L. K. Pohl, Colonel, MC 128

RESTRICTED

TRUE COPY EXTRACT - Continued - Colonel F. A. Blesse, MC, USA

"j. It is believed that the training of specialists is beyond the needs of the Corps. This should be given careful study to insure coordination with actual requirements. The limited authorization of medical officers for Station Hospitals does not permit the assignment of officers who can function only within the limits of a specialty. More attention should be given to the need for general practitioners and station hospital requirements.

"k. The training of Medical Service Corps officers must be carefully studied and improved. There will probably be a demand to reduce the number of medical officers required by the military forces and this can only be accomplished by substitution of specially selected and trained Service Corps officers. They are not available at present and steps should be taken to select the best Medical Service Corps officers possible and broaden their training. Well planned training courses in preventive medicine, emergency treatment of casualties, and other duties not purely professional, may qualify many of these officers as replacements. More must be sent to our higher level schools and the general morale and prestige of this Corps must be improved in order to attract better candidates. ~~same~~"



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. R. Urban (MC) USN
dated 28 April 1948)

***** "(b) Professional and military emergency training programs within the Armed Forces.

"(1) There was an excessive amount of military training for officers, especially in the Army. It has been stated that in some cases the rugged training program was carried to the detriment of health. (Army)

"(2) I believe a pamphlet about the administration, organization, and routine reports of the Navy Medical Department in the field, ship and shore establishment be issued to all incoming medical officers would be of help.

"(3) Since civilian physicians are averse to regimentation, military training should not be over-emphasized.

"(4) It has been noted that there was a non-availability of medical reference texts and professional publications for tactical medical officers of the Army in the last war." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. C. Greaves (MC), USN
dated 17 April 1948)

***** "Consideration should be given to the future of the Regular Medical Corps. Perhaps a modified V-12 program should be considered. Carefully selected first year medical school students in terms of physical and mental qualifications might be enrolled in a Medical Training Corps on a basis similar to that of midshipmen and cadets, with regular medical school instruction given at government expense at the various civilian medical schools. Trainees could be required to spend a portion of the regular summer vacation periods receiving instruction in the military aspects of the Medical Services. Upon completion of the 4th year in medical school trainees could be given competitive examinations to determine their precedence within their class, after which they could be commissioned and ordered to duty as interns in Naval and Military hospitals. Such men would necessarily be required to serve a specified period of time in the Medical Services before their voluntary separation would be considered.

"Routine professional instruction of the great majority of civilian candidates for the Medical Services is probably unnecessary. They are as well qualified professionally as their instructors, probably more so, since they have been practicing in a highly competitive field. More attention should be given to teaching them the military aspects of the Medical Services. They should be fully indoctrinated in the fact that an Armed Forces Medical Officer is not only a physician but a military officer as well and, as such, has definite responsibilities and obligations which are distinct from those required in treating the sick and wounded. They should be instructed in these responsibilities. One of the unfortunate situations in the last war was the attitude of the Reserves toward their responsibilities in promoting morale by upholding discipline with justice and firmness and exerting the qualities of leadership toward their subordinates. High morale is a priceless ingredient of a military organization and it stems from discipline and leadership at the top." *****

RECORDED
L. K. Pohl

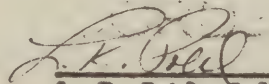
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Robert E. Peyton, MC, USA
dated 19 April 1948)

*****3. Management and Leadership. Management is just as essential to medical success as are the purely technical (professional) procedures. The success of the medical service depends equally on both. I am sure that the Medical Department, unified or separate, cannot win a war, but I am confident that it can lose one. We had in the Medical Corps of the Regular Army in World War II about 1,000 Medical Corps officers who had the versatility to provide a management nucleus for 45,000 other Medical Corps officers throughout the world. If we cannot look forward to proper and timely management and leadership we will fail as soon as we are tested. I firmly believe that every regular medical officer should be given every bit of medical training in peace time that he can take, but on top of that he must be capable of leadership and staff understanding when the time comes that the Army must mobilize for war. This is of particular import when time is of so much more importance than formerly. In peace time we cannot rely on the emergency officer to do our professional work, and in war time we cannot rely on the emergency officer to provide the management nucleus essential to success. Therein lies the key to our training. In peace time we are forced to a dual mission -- i.e., to take care of the sick and to train a management nucleus for war time. In order to do both these things, adequate provision of medical personnel is necessary. *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extracts from Ltr Col. Harry G. Armstrong, MC, 16 April 1948)

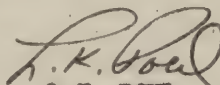
****** "b. Professional and Military Emergency Training Program Within
The Armed Forces.**

(1) Defects:

- (a) Insufficient medical personnel to permit wide spread specialized training.
- (b) Insufficient training in specialties required in military operations, such as plastic surgery and psychiatry.
- (c) Emergency training at military professional schools often on a "quota" basis.
- (d) Insufficient administrative officers trained to take load from professional personnel.

(2) Remedies:

- (a) Selection of key personnel for specialty training.
- (b) School assignments based on interest rather than the use of the "quota" system.
- (c) General indoctrination of civilian components through extension courses or lectures. ****


L.K. POHL
Colonel, MC

RESTRICTED

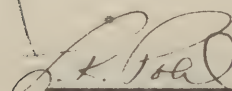
RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Arthur B. Welsh, MC, USA
dated 19 April 1948)

***** "b. The Medical Department Mobilization Training Program in the Army Service Forces was well planned and well carried out. Inspection of technical medical training was denied The Surgeon General. For example, within the Army structure The Surgeon General couldn't inspect air force or ground force medical training. It was much easier to inspect the medical service of an overseas theater! The Army Ground Force Medical Section and Service Command Surgeons' Office were too small for the jobs to be done. Army zone of interior hospitals might well have 'sponsored' overseas fixed hospitals.

"The Medical Department failed to provide schools for training higher staff medical officers, hospital commanders, and logisticians -- particularly those required for army, communication zone, zone of interior, and joint staff positions.

"The Military Surgeon, a long established and esteemed position in military history, was almost overshadowed by 'Fellows' and 'Board members'. The pendulum swung too far toward specialization. Professional courses in field medicine and surgery and in preventive medicine should have been given to more medical officers." *****



L. K. Pohl, Colonel, MC

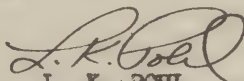
RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr W. H. Michael, Rear Admiral (MC), USN Retired)

**** "Emergency training, I believe, was one of the weakest links in our utilization of medical personnel. As far as I know it was left entirely and without direction to the Senior Medical Officer and almost always neglected. At Long Beach Naval Hospital, I carried out this program for each newly commissioned officer reporting:

1. Immediately reading in my office a 15 page article: "You're in the Navy Now," an article I wrote in 1940 for the purpose of instructing reserves entering the service.
2. Accompany inspection parties until he had seen all the hospital in every detail.
3. Spend a day in each administrative office.
4. Reading of organization of the hospital.
5. Careful demonstration of field and non-hospital procedures at weekly staff meetings.
6. Explication of differences between Naval medicine in war and civil medicine." ****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain R. F. Sledge (MC) USN
dated 26 April 1948)

***** "2. (a) Professional and Military Emergency Training
Program within the Armed Forces.

"Consideration of Training Programs for regular and medical reserve personnel in Chemical and Bacterial Warfare and in Radiological Defense for each Naval District should be considered. Such programs could be conducted by the Army, Navy and Air as a joint program. Credit for time spent by the reserve forces in attendance could be handled in the same manner as any other reserve training time. However, while the basic training for the three services is similar, there are principles of application peculiar to each requiring special training to meet the needs of that service therefore it is believed each service should be responsible for reserve training.

"Reserve Hospital Corps Officers or Medical Service Corps Officers should be assigned to the nearest Naval Medical Supply Depot for a two or more weeks training. The Naval Medical Supply Depot, Brooklyn, N. Y. can accommodate from four to six such Officers at all times. A Reserve Pharmacist has just completed two weeks of training and stated that his stay had been very profitable and instructive." *****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Captain W. D. Small, (MC), U. S. Navy,
dated 5 May 1948)

***** #3. Professional and military emergency training programs in the Navy during World War II fell far short of what could have been done for adequate preparation of medical personnel freshly recruited from civil life. This was due in part to the fact that, at least early in the war, few of us in the regular Navy really knew what we were up against, and there was too much misdirected and unorganized effort at indoctrination. There should be

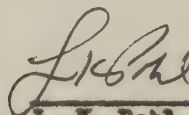
(a). A continuous, well-integrated, progressive, and, if advisable, repeated program of instruction for medical officers of the regular Services to include

- (1). Professional subjects.
- (2). Military application.
- (3). Personnel management.

The current courses at Edgewood Arsenal are a long step in the right direction.

(b). An intensive course of instruction and indoctrination of reserve officers as soon as called to active duty based on the above training of regular officers. A modification of graduate training programs currently given in most Naval Hospitals could be effectively employed. To me, the most important point is that training should be given by those fully qualified to do so and by men whose opinions and statements newly recruited reserves can respect. "*****

RECORDED



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 Apr 1948

***** B. BRIGADIER GENERAL MARTIN: Do you consider purely military training necessary for a nurse as she enters the service; if so, to what extent?

COLONEL PHILLIPS: Yes, I do. The nurses, when they come in, are prepared professionally, but they know nothing about the military organization. I think that, had we been able to give them some orientation, their attitude in certain of our problems might have been different. They have to know something about the regulations pertaining to their corps, the customs of the service, and how to take care of themselves if they are out in overseas areas. We gave, I think it was, a month of basic training, and that certainly was not too much. In the early part of the emergency, we had just a short orientation, no formal program set up, whatever any of us, as older chief nurses in the Army, could give them that we thought would be helpful, to them. It wasn't until October 1943 that we got our basic training program set up. The nurses who had it felt that they gained much from it. The nurses overseas who worked with the girls who later had the basic training said they felt those people came better prepared, and many of the returning nurses later on asked if they could go through the basic training. Now we have a two months' basic training set-up for all our nurses who come into the service with no previous military service. I think it's very important.

REAR ADMIRAL ANDERSON: Where do you give the orientation training?

COLONEL PHILLIPS: Down in Brook General Hospital.

REAR ADMIRAL ANDERSON: At the Hospital.

COLONEL PHILLIPS: Yes, at Brook General Hospital where most of our schools are conducted. They are not assigned to the hospital; they are assigned to the school. We had nine centers during the war, one in each of the nine service commands.

BRIGADIER GENERAL MARTIN: In that connection, was it necessary to provide training in the specialties within the Nurse Corps for selected nurses?

COLONEL PHILLIPS: It would have been helpful, but we were in no position to do it during the war and made use of their basic nursing training to meet our needs. In our programs now that we set up which we intend later on to open up to some of our reserve nurses who may want to come in for a short period of service, we will have them trained in certain specialties that they are interested in. In that connection, we had to set up training courses for anesthesia. They were very short courses, and those people did very well. We are retaining some of them to allow them to meet the requirements of the Nurse Anesthetist Association. We could never have met our needs for anesthetists without that program.*****


L.K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

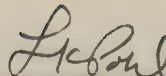
TRUE COPY EXTRACT (Letter, Captain Emmett D. Hightower (MC), U. S. Navy dated 21 April 1948)

***** "(b) The Reserve Medical Officers should receive more indoctrination and training in military methods and paper work during time of peace and before an emergency arises. During an emergency, it would seem logical to retain certain younger regular medical officers in the United States for intensive training in specialties rather than assign them to sea or foreign shore duty. At the end of the war, the medical services would thus be strengthened when the Reserves are demobilized." *****

TRUE COPY EXTRACT (Letter, Brig. Gen. George R. Kennebeck, DC, Air Force dated 7 May 1948)

*****"It is believed that in an emergency little, if any, formal professional or military training programs should be formulated for dental officers. These officers should be utilized to the maximum in the great amount of dental service that will be necessary and during the emergency should not be required to undergo formal training that will interfere with this primary mission.

"Dental reserve officers in peacetime should be given professional training in military installations of at least one month each three years. During this month they should receive sufficient military and administrative instruction to insure efficiency in the functioning as a dentist in an emergency. In my opinion, funds expended in peacetime for purely military instruction, or medico-military training, of dental reserve officers is a waste of both time and money as well as resulting in the lowering of morale of the officers concerned. Most of such instruction received is seldom utilized by dental officers in an emergency."*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E.R. HERING, JR., (MC) USN ON 22 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** B. "I don't want to put the blame on anybody, because I realize that nobody could accurately foresee what they were getting into. However, the most dismaying thing about this from my angle is that no steps are being taken to prevent this similar occurrence in the future. We are training absolutely nobody for amphibious medicine either for employment afloat or employment ashore. There are no schools for this particular training; and what training they do receive is strictly hit or miss. For instance, in my organization now I am the surgeon in charge of all the Fleet Marines for the Atlantic.

The Army did certain things along this line, and the publications were available to us, and that is in standardizing treatment. You had just about as many types of treatment in various conditions as there were doctors. There was the handling of fractures under various conditions. We all know that perhaps the best treatment of a fracture is to get him up in an extension, and so forth. But there are certain places that you can't bog yourself down, in the forward areas, with 250 or 300 fractures in extension. So any doctrine along that line, as well as along an operational line, on the standardization of treatment, in view of the fact that we don't have time enough in an emergency to pull these men in and give them these courses, is certainly necessary in my opinion; and is the place to teach it, I think, -- and I think it would be very popular, is among these civilian people. Not only would it be excellent for their professional development, but it would bring them closer to us, the Regular Service, if we do have these courses available in certain areas -- I mean large universities -- and make these courses available to these people.

This goes back to what I said about indoctrination and morale. If these people are carried along with us in our developments and are more fully equipped to step in when they are needed, and have some idea what to expect, I think you will find that their morale will be 1,000 percent higher.

Professional and military emergency training programs within the Armed Forces. Again, my experience has been with operational forces rather than with those forces in the continental limits. I feel very strongly that we should not tie a great number of medical personnel down with our operational forces during peacetime. However, we have to have trained personnel for those operational forces.

It is not fair to the military or to the doctor himself to throw a man in untrained. I have written a plan for particular training of personnel in my field of endeavor, amphibious medicine. It was submitted 1 1/2 years ago to the Bureau, and to BuPers. Briefly it is this: that if we could, during the period of our yearly maneuvers, assign medical personnel, both officers and even enlisted men, to bring us up to strength, and have an indoctrination period of 2 or 3 weeks and accompany the military on the maneuver -- for, after all, it is there that you learn the stuff in peacetime, as much as you can -- and then possibly two weeks after that for critiques to gain any new ideas, as that new blood coming in might have new observations, and then possibly an interview by a board with the ultimate view of qualifying or earmarking such personnel, as seem to have the necessary attributes and that take an interest in this, as field medical men.

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E.R. HERING, JR., (MC) USM CL. 2 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES CONT.

Right now nobody is being trained. On the other hand, I am tying up possibly 5 or 6 more medical officers than I need because I am taking what I can get. In other words, instead of telling the Bureau what I can get along with actually, for medical needs 4 or 5 less personnel, because I am right under the gun with my outfit I naturally want to keep myself up as near as I can to the absolute strength. In the long run it would mean a saving of 50 percent in my outfit alone, if I could have a minimum of 10 medical officers assigned for a period of 2 to 2½ months. I feel that we could give them the basic indoctrination and demonstrate for them the employment of forces in the field. Then we could earmark certain personnel who have the interest. We could take those people and send them to our staff schools for further training; and in the end we would have what I am looking for -- trained staff medical officers. We would be doing away with a lot of the unhappiness that accrues when you take a man and stick him in a dispensary for along period of time.*****

RECORDED
L.K. Fohl
L.K. FOHL, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** (B) 1. I really don't believe that he should. They have have an instructor go to the unit and give basic military training that is needed but not for them in large concentrations.

"2. When officers are inducted into the service provision should be made to teach them traumatic surgery, preventive medicine and radiation injury. This should be done in the unit.

"3. I don't believe correspondence courses are of any overall value to doctors in civilian life because they don't apply themselves to them. I think they could be taught better after they enter the service.

"4. I don't believe that extension courses were utilized to the fullest extent. They could have been very valuable if they had been used but the doctors didn't have a tendency to work at it.

"5. I believe it would be better for enlisted men to be indoctrinated into centers. I believe it is necessary.

"6. I don't think we should be willing to accept lower mental grades because they are of very little value to the Medical Department. Their proficiency as technicians is very low and if we have to take a share I think it should be absolutely minimum. A lot of people thought during the last war that they could pick anybody for a litter bearer but if they weren't in excellent physical condition they could not carry out their work."*****

***** "8. I believe that once a soldier is accepted by the Medical Department and has worked there for a while he should not be transferred. If we transfer them out we have to transfer them in. Men with line experience don't adjust very well to the Medical Department. I think to have this implemented there would have to be an overall policy by the Secretary of Defense."*****

RECORDED
L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

Extract of Statements made by Brig Gen Robert C. McDonald, MC, USA (Retired), 21 April 1948, before the Subcommittee on the Employment of Military Medical Resources.

*****Regarding the second subject, "Professional and Military Emergency Training Program within the Armed Forces."

"Professional training of medical specialists in W.W.II, lagged behind requirements. Courses were too short, while on the other hand, military emergency training was more than adequate for many medical specialists."

I think we ought to give minimum military training to our specialists, those who are already qualified, and the maximum of professional training.

I recall that I felt that my neural surgeons weren't well enough trained. They started in to do the neural surgery work after the advance into Europe from England. We got many of those cases and they were very difficult cases, and I had very young men doing that work, and it was almost impossible for them to keep up with them. They did not have the dexterity, perhaps not the basic experience to do the work well.

I think that we should estimate our requirements of these highly-trained technical specialists as far ahead as we can. We undoubtedly have that pretty well done now and could call them into the service in time to give them post-graduate or refresher courses in their technical work so that when we do need them we would have them ready. At the time that they completed their training, if they were not then needed in the service, they could be returned to civil life and form a reserve."*****

I certainly do favor the establishment of some sort of an institution which would collect, evaluate, develop, and disseminate professional knowledge and recent advances in the medical military fields. I don't see how the best advantage can be made of these advances unless we can have a well-organized efficient organization to do that work for us.

I don't know right now where you could go to find the advances in medicine for the past years. I know the only place that I would go would be the World Almanac, and there you would find a list, a page or two, of advances in medicine and surgery. Some medical journals may publish that, but I hardly ever see anything of that nature published.

I am heartily in favor of the collection, evaluation, development of all of this research information and its dissemination to the proper institutions of the armed forces."*****

"Do you consider it necessary to give all medical officers a basic military course on entry into the service? If so, how long should it be: Should it be restricted to certain ranks, say below majors? Can this course be given at other than training centers, such as hospitals, units, etc.?"

Basic military training for medical specialists should be very brief and can very well be accomplished at hospitals and other medical units without the necessity of sending the officer through a basic training camp. I think much time of specially trained medical people was wasted in World War II by having to undergo long courses of basic military training.

RESTRICTED

RESTRICTED

"What professional training, if any, is necessary for all medical officers on entry into the service? Did we assume too much knowledge in that category in military surgery, preventive medicine, etc.?"

Certainly evaluation of the professional training that a medical officer has had should be made when he comes into the service, to determine whether or not he is qualified as registered in the National Registry, for example, if we have one.

I think we did assume too much knowledge in that category. A military surgeon would come in, in preventive medicine, in many cases.

"Under a National Registry do you think we could set up a correspondence course of worth for all medical officers during peace which would cover the purely military phases of surgery, medicine, preventive medicine? Would this eliminate the need for professional training on their entry into service?"

I do not think that a correspondence course should be set up for each person in the National Registry. It should, however, be provided for each applicant who applies for the course and certified that he will go through with it. I think a lot of money and time would be wasted on perhaps two-thirds of them. They would throw it in the waste basket and cuss you at the same time. I believe it should be done for those who are interested and want it, and not forced upon others.

"Say the Organized Reserve."

That's right. It would reduce the time required for professional training when they come into the service, and in many instances probably eliminate it.

"What is your opinion as to the demonstrated value of extension courses for reserve officers?"

Very low value. I don't think they have been worth the money, in paper, that they cost at all.

"For enlisted men -- do you think a basic course in medical subjects is mandatory? At training centers? On the job?"

I believe the training system that we had, of giving basic courses at our various medical schools, was very valuable. I don't think they could get the training on the job at all and have the hospital, where they are getting it, operate with any sort of efficiency." ****

"Did our training programs for enlisted specialists prove of value? If not, what do you recommend?"

It proved of great value. I recommend that it be continued with such modification as progress may indicate."*****

"Do you think our separate residency training programs in the federal services would be improved by more closely coordinated effort?"

Yes, I think it could be improved."*****

RESTRICTED

L. K. Pohl
L. K. POHL, Colonel, MC

RESTRICTED

TRUE EXTRACT COPY

(Extract of statements made by Colonel Thomas J. Hartford, MC, USA on 23 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

***** "b. Insofar as basic training, we have a large reservoir of people now who have had some military training, but I believe that a short course of indoctrination is necessary for everyone if for no other reason than it gets rid of the inferiority complex that everyone carries around, because we are still going to operate within the framework of the services.

I don't think we can have a separate medical Army, and a little training is necessary. If they haven't had it, they have to have it. I don't think it has to be too long. I think a lot of it could be within units and I am talking about officers and that the strict specialists -- and I am talking about specialists, consultants, and so forth -- perhaps a week of indoctrination for those officers who have had no military service might suffice.

I think another erroneous thing, we have a lot of people believe that every doctor that graduates from a good medical school knows something about preventive medicine, and that isn't true at all. I find that they don't have any conception about it. I had a very little when I came out of medical school as we did have a short course in tropical medicine, so-called, in my particular school because we had a retired colonel in town who liked to teach. So at least I had heard of a few things about preventive medicine, but I find students who are recent graduates of good schools who don't have the slightest idea about it.

I certainly concur in such a scheme, an armed forces and civilian medical institute primarily devoted to subjects of military and civilian defense--I suppose the civilian defense part of it would be as much emphasized as the other--especially post-graduate education, more on military lines.

I think that the civilian institutions can and should conduct a good many of our courses, but for more along military lines and for the digestion of the large amount of material that is available, which we haven't done too much with, I would think an institution like that would be a wonderful thing, especially if it were a joint activity of all the services.

There isn't any question that we would have to have civilian because regular Army I presume took less than two per cent of the total Army and the medical strengths are approximately the same, so if we leave out the civilian of course, it's obvious that we haven't covered the field at all.

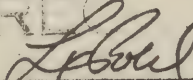
RESTRICTED

RESTRICTED

RESTRICTED

CONT'D

*****b. We have been very interested, especially when it comes to radiological defense and matters of that nature, in that the civilian profession rather looks to us to give them some assistance, but the job is a little too big for us right now and we haven't even trained our own instructors along that line; but when we do I think we owe it to the civilian population to assist them, which this institution would, and with their help it probably would be of much greater benefit to everybody. *****

REC


L. K. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - APTAS.

***** B. "Likewise, the cause of more efficient training and closer liaison between air force medical staffs and those of the general hospitals were promoted, beginning in 1943, by the periodic assignment of Air Force medical officers to general hospitals on temporary duty for thirty days. Here they had an opportunity to refresh themselves along professional lines and at the same time become acquainted with some of the innovations in medical science. This tour of duty was of special value to medical officers in the field. In December 1944 a clinical post-graduate hospital tour of duty (extended from thirty to forty-five days (in March 1945) was arranged for Air Force medical officers. Authority to train Air Force Medical Department enlisted men as medical, surgical, laboratory, and x-ray technicians in United States Army Communications Zone hospitals was granted by Headquarters, European Theater of Operations, on 3 March 1945. Specially qualified hospitals during 1943 and 1944 conducted 3-day courses in "plaster of Paris technique" for selected medical officers, one usually being chosen from each operational station. During 1944 the 312th (US) Station Hospital opened a 6-day course in neuropsychiatry which stressed the importance of early recognition and initial treatment. The hospitals also set aside periods to instruct Medical Department enlisted men in operating room and laboratory technique, medical nursing, physiotherapy, pharmacy, and radiology. The medical officers at the various Eighth Air Force stations instituted a continuous training program designed to qualify capable enlisted men for MOS ratings. Sixday courses were offered emphasizing the practical phases of chemical warfare and the proper methods for treating gas casualties.

Eighth Air Force Central Medical Establishment. The most determined and successful efforts to overcome the lack of training on the part of Air Force personnel in the medical aspects of their duties and obligations were manifested in the establishment and maintenance of an institution known at first as the Eighth Air Force Provisional Medical Field Service School. It was authorized by the Commanding General of the Eighth Air Force on 24 May July 1942, activated by General Order No. 14 six days later, and officially opened by Colonel Grow, Eighth Air Force Surgeon, 10 August 1942, at Pine Tree, England. It was designated the Eighth Air Force Central Medical Establishment 9 November 1943 by General Order No. 205.

Operating under the general supervision of Col. H.G. Armstrong, the establishment was divided, primarily for administrative purposes, into five units, namely, the 41st Altitude Training Unit, the Psychiatric Unit, the Research and Development Unit, the Central Medical Board, and the School Unit. The task assigned to it was a heavy one involving great responsibility. A survey conducted in 1942 revealed that approximately two-thirds of the medical personnel assigned to the Eighth Air Force had had no previous training in aviation medicine and that many were without military training and experience of any significance. In February 1943 it was reported that only 10 percent of those assigned to the tactical units had been trained in aviation medicine. The need for such training was no theoretical postulate. Untrained medical officers could not indoctrinate flying personnel in the physiology of flight and teach them the proper use of protective flying equipment. Lack of training in matters of this kind was held directly responsible for the loss of three 4-motored heavy bombers and ten airmen within a period of a week or so during the latter part of 1942, and for other serious accidents up to that time.

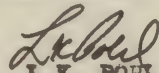
The primary purpose of the School Units was to provide the basic courses and instructional facilities needed to indoctrinate Air Force personnel, especially medical officers, in the physiology of flying and in the use of protective

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS, CONTINUED:

equipment. To this end a number of courses were organized. The Medical Officers Indoctrination Course was devoted almost entirely during 1942 to instruction in aviation medicine. Thereafter, because most of the incoming officers had graduated from the School of Aviation Medicine, the emphasis was shifted to the most recent discoveries in military and aviation medicine and to the special problems being encountered by Eighth Air Force personnel. Some instruction was devoted to the organization of the Air Force, the sources of medical supplies, the location of hospitals, and other similar matters calculated to orient them in their general duties. At the direction of the Surgeon of the Eighth Air Force, courses for flight surgeons were given at intervals between August 1942 and March 1944. During this period 902 flight surgeons and 36 medical officers enrolled for the training. The training facilities of the Unit were not restricted to medical personnel. Initial courses for oxygen and equipment officers began 7 December 1942.*****



L.K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS.

***** B. "At approximately the same time (July 24) the Commanding General of the Eighth Air Force authorized the establishment of a Provisional Medical Field Service School for the training of Eighth Air Force medical officers in the elements of aviation and military medicine.

This action was a serious blow to the Surgeon of the Eighth Air Force. He wrote that the memorandum from the Headquarters, ETOUSA, Office of the Surgeon, to G-3 recommending disapproval of the proposed Table of Organization for the school "indicated that the originating agency has little conception of the requirements for an adequate Medical Service for the Air Forces in this Theater of Operations" and manifested "a total disregard for the welfare of Air Force Combat crews". In substantiation of this opinion, he quoted the following statements from the memorandum and commented upon them to show that they were "contrary to facts" and utilized reasons for recommending disapproval that were "entirely foreign to the matter at hand". "Para 2a of the above mentioned memorandum states: "The training of flight surgeons is a responsibility of the War Department at home in the School of Aviation Medicine".

Records of this office show that 76.1% of the medical officers thus far sent to this Theater of Operations for duty with the Air Force to date have not been trained as Flight Surgeons at home in the School of Aviation Medicine. Thus the foregoing statement is a criticism of the War Department which, according to the above, quoted statement, has not met its responsibility in this respect. The fact that the War Department, due to circumstances beyond its control, has not been able to train the required number of Flight Surgeons does not relieve its representatives in this Theater of Operations from fulfilling their responsibilities in this regard.

The Need for Medical Training. The first few months of aerial warfare brought to light astounding evidence that Air Force personnel, including the medical staffs, were not adequately trained in the medical aspect of the duties for which they were responsible. A majority of the medical officers had had no training in aviation medicine and a considerable number of them had just entered military service prior to arriving in the European Theater. Furthermore, there were too many high ranking officers in higher echelon positions who were totally lacking in the proper perspective and knowledge of the problems that confronted tactical units. Lack of understanding on the part of flying personnel concerning the care and use of protective body armor, oxygen cold and first-aid equipment accounted for the loss of lives and planes.

Knowledge and ability to apply the elementary principles of first aid were not always found among the Air Force crews. It was generally recognized that if a "representative proportion of the medical department enlisted men were well trained, higher caliber individuals" and basics assigned in sufficient numbers to meet work requirements, the detachment personnel could be reduced one-third and at the same time be more efficient.

Several factors were responsible for the fact that 65.9 percent of the Air Force Medical officers in the European Theater at the beginning of the war were not qualified to perform their duties. In the first place, as suggested above, many of them were shipped across the Atlantic almost immediately after having

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS, CONTINUED

entered military service and without any previous training in the physiology of flying. Secondly, a majority of the officers assigned to the European Theater were "not of a type basically suited" to become flight surgeons. In the rush of expansion the emphasis was placed on "numbers rather than quantity" wrote the Air Surgeon. A mistake "in concentrating everything on the idea of the flight surgeon being a 'hail fellow well met,' instead of a professionally qualified individual".

In the third place, the training provided at the School of Aviation Medicine, Randolph Field, Texas, was inadequate. It was estimated in January 1942 that "99% of the efforts" at the School were "in the direction of the 64 examination," in spite of the fact that it was then apparent that the ability to conduct such an examination was of "relative unimportance in actual warfare in the combat zone except on rare occasions." Furthermore, other aspects of the course were usually responsible for the hospitalization and treatment of the seriously ill. In the combat zone, knowledge concerning sanitation, records, the defense against chemical attack, the organization of airdromes against enemy bombing, and the ability to indoctrinate combat crews in the physiology of flying and in the use of protective flying equipment were of utmost importance to Air Force medical officers. The latter two, wrote Colonel Grow, could not "be over-emphasized and are the weakest points in our training of medical officers in Aviation Medicine". The need for more "tactical training" for flight surgeons had long been obvious.

Training Program Established. Perhaps, the most successful endeavors to overcome the shortages of medical personnel were not manifest in efforts to secure more medical officers for the Air Forces or to provide more flexible Tables of Organization, but in the determined and concentrated efforts of the Surgeon of the Eighth Air Force, Col. Malcolm G. Grow, to provide training facilities for the medical manpower he already had under his supervision. The objective of the Eighth Air Force medical training program was to improve both the professional training of Medical Corps personnel and the indoctrination of non-medical personnel in preventive medical measures and simple emergency therapeutic procedures. Medical training schedules for Medical Corps personnel were at one time submitted three months in advance by all units. Schools were established to train medical officers in special fields of aviation medicine, arrangements were made for them to take courses offered in British schools; and, in order to keep them abreast of the advances being made in the application of military medicine, they were given temporary assignments to general hospitals. The reading of medical publications was encouraged and societies were organized to promote discussion of timely topics.

An Allied Forces Dental Society was organized to promote professional and social relations between dental officers representing various nationalities. After the formation of the Inter-Allied Medical Society, monthly meetings were held at the Royal School of Medicine to promote professional interests, and during 1944 the Eighth Air Force attendance allotment of five officers for these meetings was rotated to representatives of the major subordinate commands. Numerous medical officers were admitted as fellows to the Royal Society of Medicine and attended its meetings.

RESTRICTED

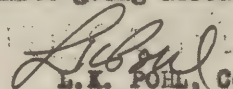
RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS, CONTINUED

First Aid, Use and Care of Protective Equipment, and First Aid for Enlisted Men and Crews. The emphasis placed upon the training of commissioned officers at the Central Medical Establishment should not be allowed to completely overshadow the importance attached in the European Theater to completely overshadow the importance attached in the European Theater to the training of enlisted men and crews in first aid, night vision, and those elementary principles of aviation medicine which they would ordinarily be expected to apply under numerous and varying circumstances. The indoctrination of combat crewmen by medical officers in first aid, oxygen, protective clothing, and the medical aspects of ditching was a continuous process.

Institution of Training for other Theaters of Operations. As the end of hostilities in Europe approached, the Medical Department of the Air Forces in Europe took steps to indoctrinate the medical officers on the problems which would confront them in other theaters of operations. In April the Medical Section, USSTAF in Europe (Bear), in cooperation with the Surgeon of the Eighth Air Force, made plans for the establishment of the Medical Redeployment School at Bryanston Square, London, within convenient access to government mess and billets. Classrooms and special equipment were secured. British civilians familiar with climatic conditions in the Far East and the practice of tropical medicine and medical officers from the Army Air Forces operating in the China-Burma-India Theater and the Far East Air Forces were secured to instruct and act in an advisory capacity. The school held a total of five 3-day sessions. Each was attended by fifty-five medical officers, 2, on an average, being chosen from each station and unit under the technical command of the USSTAF. The courses covered such subjects as personal health in the jungle, medical and administrative problems in eastern theaters, intestinal parasites, diarrheal diseases, food inspections, scrub typhus, malaria, insect control, water inspection, psychiatric screening, air-sea rescue, personal equipment, sustenance kits, homologous serum jaundice, and the transportation of pets. The lectures and informal discussions were supplemented by training films, lantern slides, posters, and exhibits of various kinds.

In addition to the training provided in the school, the Sanitary Engineering Section prepared a bulletin on the nature of the various communicable diseases prevalent in the Pacific and CBI areas and the precautionary measures which should be used to combat them. Information on veterinary problems in the Pacific Theaters was gathered and distributed to the units going abroad.*****


L.K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT FROM AIR EVALUATION BOARD SWPA REPORT NO 35. THE MEDICAL SUPPORT OF AIR WARFARE IN THE SOUTH AND SWPA FROM DEC 7, 1941 TO AUGUST 1945.

***** B. "The training of the majority of Flight Surgeons did not equip them with the fundamental knowledge required to solve successfully the many problems in military and aviation medicine which were encountered in these theaters.

The training of the majority of Flight Surgeons did not prepare them to cope properly with certain fundamental problems in military and aviation medicine encountered in these theaters."*****



L.K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain W. C. Eady, Jr., (MC), USN
dated 19 April 1948)

**** In view of the possible war requirements of naval medical service, it is believed most desirable that as many medical personnel as personnel ceilings will permit attend an indoctrination course in the medical aspects of amphibious warfare. Such a course might well be established as a joint armed forces project. This recommendation is made in view of the difficulty encountered by the Bureau in meeting its obligations during the last war and in view of the very limited number of medical officers and enlisted men now familiar with Medical Field Service." ****



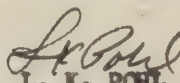
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Albert T. Walker, Captain, MC, USN, 26 April 1948)

**** "With respect to professional and military emergency training programs within the Armed Forces, I believe a great deal of this should be accomplished in the medical schools and after graduation while medical officers are in a Reserve status as stated above and should not be left for the emergency period when the services of all medical officers are going to be required on a full-time basis. During the last war, we had too many medical officers tied up in training programs and other unnecessary duties which left those of us in the field with insufficient help to handle the casualty and epidemiological problems properly. Training should continue throughout the medical student's full course as a part of his obligation as a doctor to his country."****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr M. C. Stayer, Major General, U. S. Army, Retired 19 Apr 48)

****(b) Professional and military emergency training programs within the Armed Forces.

It is my belief that it is highly necessary to give men training as was done in the military emergency training programs during the last war. Many of the men taken in do not understand the profession of arms and should have an education that would integrate them with the Armed Forces. Professional training has been given these individuals, and I think it is a duplication of effort during an emergency to give any further training of this type, except in so-called tropical medicine. Such a school was established in the Canal Zone.*****

L. K. POHL
L. K. POHL
Colonel, MC

RESTRICTED

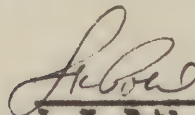
RESTRICTED

TRUE COPY EXTRACT (Letter from Rear Admiral A. H. Dearing (MC), USN
dated 26 April 1948)

**** "(b) Professional and military emergency training programs within the
Armed Forces.

The writer observed several instances in which promising young surgeons were placed under the training of older and experienced individuals in Naval Hospitals, upon the request and recommendation of the Medical Officer in Command of the hospital, only to have them ordered away within a short period after starting their training. This created an impression among the experienced specialists of the Reserve who was called upon for training these men, that the detailing authorities in Washington did not have any firm policy with regard to training." ****

RECC



L. K. Pohl, Colonel (MC)


RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel R. E. Stone, MC (Res.) Air Force
dated 22 April 1948)

***** "When men in the service are needed for advanced training, feel that more careful consideration should be given to the selection of that personnel. Only have knowledge of personnel sent to the School of Aviation Medicine for training in Flight Surgery. It is my conviction that too often a Base Surgeon used this means to cull his staff of the less desirable personnel and those persons with the personality, tact and ability to make good Flight Surgeons were thus deprived of the training. In the end, it was the Medical Service of the Air Force that suffered from such a practice."*****

RESTRICTED



L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Earl Maxwell, MC, Air Force
dated 19 April 1948)

***** "3. In general, it seemed that the Commanding Officers of the hospitals coming overseas had had insufficient training, but the remainder of the personnel were well trained. Therefore, it would seem indicated to give Commanding Officers additional training."*****

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

**** "b. An indoctrination period of training, both professional and military, should be attended by all who are commissioned directly from civil life with no previous medical reserve corps training. Courses should be on a different plane for well qualified specialists who will serve only in hospitals or as consultants; their course should be designed to familiarize them with military procedures and methods only. It is also my belief that a comprehensive course in military medicine should be included in all medical and dental colleges." ****



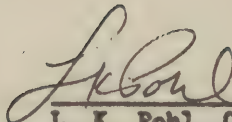
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Dr. Martin Karr - dated 3 April 1948)

"As far as indoctrination is concerned, I think this could well be taken care of by making it mandatory for this group to attend classes, either one a week, or in the evening, or twice a week, or any other stated time, so that they would be up to date on the Army's latest practices and problems so that if they were moved from San Francisco to Berlin, they would still be able to carry on and not be as civilians who would suddenly have to find themselves all over as far as an Army routine is concerned."



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE MEDITERRANEAN THEATER
HISTORICAL SECTION - APTAS

***** B. "One surgeon suggested rather caustically that it should be compulsory for the commanding officers to attend these schools, for it was his experience ... that lack of appreciation of the problem and interest in application of control measures by commanding officers has been and continues to be the most important cause of the breakdown of malaria discipline."*****

L. E. Pohl
L. E. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (LTR FROM DR. H. S. HOFFMAN DTD 13 MAY 1948)

*****B. "It appears to me in the final analysis failures in this connection were due to the lack of intelligent indoctrination and orientation of the war time inducted Reserve Medical Officers. This opinion would appear to be verified in the few examples of proper indoctrination noted. In these instances dissatisfactions were infrequent. The oft heard excuse was, of course, that we were observing too many fine, capable Regular Officers with unusually heavy demands on their time and energy who still found themselves able to advise and help some of the confused Reserve Officers under their command. The chief difficulty arises from the fact that no where in the peacetime training of the regular services are officers taught that in the event of war many thousands of civilians will be inducted into the forces and since it is not feasible to indoctrinate a large group of civilian doctors in peacetime this responsibility must always devolve upon the Regulars. It is essential, therefore, that in peacetime Regular Officers must be trained to understand the elements of the problem and be adequately prepared to effect a rapid yet thorough and intelligent indoctrination of these civilians after induction. In the past, although the pattern has been repeated with every war we have fought, this item of training has been neglected and the regular forces are caught short each time without the "know how" when war begins. Implicit in this breakdown is not only that the Regular fails to do his best job in war time, but he creates a large and influential peacetime group that is antagonistic and even hostile to the Armed Forces during peacetime.

In closing I might say for the record, that while instances of inadequacies on the part of Reserve Officers was practically unheard of, nevertheless it is conceivable that somewhere in this large group there may have been a stupid ass who did not contribute substantially to good relationships between the two groups - or anything else for that matter.*****

R. E. POOL
R. E. POOL, COLONEL, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:
Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview
with Subcommittee on the Employment of Military Medical Resources

***** (B) 1. I certainly do think it's necessary to give all medical officers a basic military course on coming into the service. I have had little experience in training medical officers in wartime. I don't think they need very much. I think that it can be brief and informal and possibly even could be given at their original station. I don't think it needs to involve harding together large groups of these people for a month or two and having them pack their equipment around and pitch pup tents.

"That sounds like a quibbling answer. I don't mean it that way at all. It's necessary, but it can be practical, brief, and to the point, and I believe in most instances at least can be given at whatever station the medical officer is being sent to for his original assignment, and it shouldn't be restricted to junior officers. Everybody should get it.

"I can't answer No. 2 at all.

"No. 3, I ought to be able to answer. I had the extension courses for a little while at Grant. I doubt if extension courses on purely professional-type construction can be made sufficiently instructive to justify the effort that is entailed. By that I mean I don't think that we can keep at our schools, or at places where we prepare these courses, doctors and reviewing officers who are sufficiently up to the minute professionally and who can afford to take the time, the great amount of time involved in preparing professional-type courses.

"As far as professional training on their entry into the service, that, I think, is entirely an individual question. I don't believe that I can make a general statement as to how much professional training these doctors need when they come in because it depends upon their background and on the type of job they are going to be given when they come in to the service.

"4(B). As far as the demonstrated value of extension courses for reserve officers, I believe it's shown to be as important as most any type of training given to reserve officers. I think they get out of it what they put into it. I think that a person who is exposed to training is bound to get some good out of it, even though he may not recognize it at the time.

"I think that extension courses for reserve officers should be given in fields in which they can't readily get the material locally, and I think that extension courses should be given only as part of a recognized program for the reserve corps.

"I think it is still subject to decision at higher level whether the extension courses now being given are going to credit a man toward promotion or something else."

RECORDER*L. E. Pohl***RESTRICTED**

L. E. Pohl, Colonel, MC

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

"I don't believe they know that yet. I think a man who takes something like that, that consumes a considerable lot of time, should know it's part of an over-all training program which leads him toward consideration for promotion. I think courses that are properly written and intelligently graded are of considerable value.

"6(B). Yes, I definitely think so. I think the only way you can make a medical soldier is to train him, and I think that that is different from the officers because the officers have professional background when they come in. These people come from all walks of life and from all sorts of avocations in trades, and many of them have had no medical connection whatsoever, and all of a sudden they find themselves in the medical department. I think they should have a very definite concentrated and thorough course, starting at a training center and continuing as long as they are in the service on the job."*****

"8(B) Yes. It's one of the projects we have right now, is how can we keep our Army medical men from being dissipated from being pushed into all sorts of other fields, and we have just finished a staff study on that in which we have recommended very strongly that regulations be re-written to protect the medical department enlisted man."*****

"(M) 11. I think in answer to No. 11 that training facilities in armed service hospitals for selected civilians would definitely engender better mutual understanding of our problems. Understanding of problems always tends to iron out difficulties which are usually caused by lack of understanding of other people's problems."*****

RECORDER

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL CORNELL, MC, USA, 30 April 1948

***** B. "Professional and military emergency training programs with the Armed Forces" - The over-all need is a continuity of the program to a definite end. I have seen many training programs started but none finished. Policy changes so fast that we never were able to maintain continuity of any single training program.

I speak of that particularly with respect to our own branch in pathology. We have tried many ways to train them, but the men would be pulled out and put on something else. I think that's one of the reasons for dissatisfaction.

A permanent board of service and nonservice personnel who would be qualified directors. Probably not more than one replacement a year might produce continuity of program. Screening of personnel early to avoid waste of time on inept personnel. I feel strongly that the time we need to weed our officers is when they come up for their first promotion, and I always have felt strongly on that. The time to get rid of a man is after his first three years of service when he comes up for captaincy. The time to get rid of a resident is in the first three months. I recently had one for two years. I tried to get rid of him for a year, and I couldn't.

I think that everyone supervising personnel should try to weed out the ones that aren't going to make good early. We waste time on them which we could much better apply to someone better qualified.

Of course the old one of avoiding inflation in stagnated or inactive posts. Avoid purely administrative medical men by returning them back to professional duties periodically. That is diametrically opposed to General Hawley's idea of an administrative corps. I feel very strongly against that. I don't believe we will ever do any good to the services by having a purely administrative corps of medical men. I mean; men who become only what the services commonly used to call "brass hats". If that is to be done, we are so definitely going to divide the corps into a professional and an administrative group that they would become two distinct corps. If we need a corps of only professional men just to take care of sick and wounded; train the men in those hospitals to take over the professional duties of the services.

However, I feel that you cannot separate a professional knowledge of moderation of medicine from the administrative phase of the work. The minute a man loses his professional attitude and becomes entirely administrative, he cannot understand the requirements of the professional side of the game. I think General Martin agrees somewhat as I do on that, although I don't speak for him; only for myself.

I will say this, however: the reason I make that remark is because General Martin always backed us up on professional things without in the field looking after the professional side of it. We didn't have to argue professional ideas with him.

We have always had to struggle with under-staffing so that rotating to educational schools was meager. We need at least five to ten percent over-strength to permit proper modernizing of medical manpower. Several times in my career I have asked for details where I felt I could better myself with the service, and have always been met with the idea that I was needed in the field somewhere. That has been the case with many members of the service, I know. With leave time, sickness, school details, we need more men than are actually called for, and we can't

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL CORNELL, MC USA 30 April 1948

B CONTINUED:

train men in these other details unless we have more than the actual number required for staffing.

I also feel that some of that training could be well acquired outside of the US. I had that driven home perhaps a bit in my trip through Central America just before the war when for the first time I realized there were many things going on in those countries that we had never heard about. We knew nothing about their diseases, and there is no place you can learn about them as well as in their countries. I feel that such centers as Brazil, Columbia, right in our own hemisphere, could teach us a lot.

I believe the young officers need earlier training in staff liaison. It has been a bit of the policy to teach, you might say, the level of company medical administration to the younger group, and only to the majors and lieutenants; colonels staff liaison became more well inculcated in them, but the junior officers jump a couple of grades and immediately need that staff liaison about which they know nothing; so I think the training of junior groups should be on a higher level for future use. They are the ones that are going to have to do it from the regular service.

I think we should coordinate the general military training of all medical personnel through our state and county medical societies with perhaps officer details to regional groups. Stress to the medical profession by good representatives the new ideas that are being developed. They are all eager to hear about new supplies, new development, new equipment, blood procurement programs, atomic and bacteriological warfare. I think they would welcome such information and would like to ask questions about the service that could be answered in person, and that the service in general could be better represented to them in that way by personal contact. I think you have the general idea of what I mean there.

BRIGADIER GENERAL MARTIN: This Committee is particularly interested in elements affecting the medical services in the combined forces that must be accomplished now. Do you favor, in furtherance of your already expressed opinions, the establishment of some form of medical institute at some medical center composed of outstanding scientists, both service and civilian, which would principally gather the information of the past and that currently under investigation regarding military surgery, medicine, preventive medicine, atomic matters, and biological warfare matters; and further, could this institute give resident courses of various types to service personnel, civilian practitioners, and so forth, and further publish to the medical profession the results of their findings, including material for undergraduates, PMSAT's, et cetera?

COLONEL CORNELL: Would this be an investigative group or would it be a teaching group?

BRIGADIER GENERAL MARTIN: BOTH.

COLONEL CORNELL: Who then would be taught? I would like to get that clear in mind.

BRIGADIER GENERAL MARTIN: The entire medical profession.

COLONEL CORNELL: Both within and without the service?

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL CORNELL, MC, USA 30 APRIL 1948.
R CONTINUED:

BRIGADIER GENERAL MARTIN: Yes, that would be used in any future mobilization of medical manpower.

COLONEL CORNELL: I believe that the inculcation of a new idea and the introduction of a new plan of doing things like everything else is best begun with the youngster. You can't teach the old man to like doing things new ways. I believe that if we could get a group of younger men who knew they were coming into a combined medical service -- let's say the US Medical Service, and that they would be allowed some choice, would never be stymied in -- let's say on sea duty for ten years, and never get back to a general hospital, or they wouldn't be sent out to some small posts and left there to do small post duties all their life, and were going to be able to carry on progressive medicine with perhaps details in tropical areas and details somewhere else, always coming back and being refreshed in their medicine, I believe we could interest the youngster group in such a service.

We have seen recently a lot of young men come in with the idea that they did not want to stay in the service, but out around Walter Reed where there is lots of medicine, many of them have found out that they can get real medicine in the service and they will stay in after they have their residency depends a lot on some of the things I have mentioned like continuity of training, keeping them in professional work, having them understand why they must do certain nonprofessional duties - it's just like wiping dishes at home. There are some things like that have to be done.

BRIGADIER GENERAL MARTIN: THAT's all I have.

COLONEL CORNELL: I think in general that the scheme would be a good one and that it might be well to approach it on the younger level.*****

L. E. Foehl
L. E. FOEHL, COLONEL, MC

RESTRICTED

RESTRICTED

3

TRUE COPY EXTRA OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (C) USN 4 May 1948

***** B. " Do you have any comment to make on emergency training early in the/last war, or during the last war?

REAR ADMIRAL WILLCUTTS: I have the highest tribute to pay to ~~our~~ reserve doctors in the Navy in the last war, who came to our hospitals. They were highly skilled clinical men who were able to train our youngsters not only in clinical medicine but also in traumatic surgery and in things pertaining to emergency service. They were able to carry on in San Diego, if you will pardon me, internship that is superior or equal to anything in the land today.

At San Diego an interne completed his 12 months rotation with a score of several appendectomies personally performed, with the required number of deliveries on babies, tonsillectomies, eye examinations, fractures, and everything pertaining to not only civil medicine but to our needs as we saw it coming up in the Pacific. The training was under war conditions, but the clinical material was so rich and so great that I know the youngster in the Navy on the West Coast had good training. Now the poor devil who got out on the ships and stayed out months and months surely didn't get obstetrics and very much general medicine. But by rotation of services, I do not believe that the Navy training was too badly off.

REAR ADMIRAL ANDERSON: I gather then that you feel that the place to give what training is necessary for a medical officer as at our hospitals.

REAR ADMIRAL WILLCUTTS: At our hospitals and hospital ships.

REAR ADMIRAL ANDERSON: Do you feel, in the Navy at least, our officers should have special training for their administrative duties aboard ship?

REAR ADMIRAL WILLCUTTS: I don't think so much for administrative duties as for the special duties.

REAR ADMIRAL ANDERSON: Yes, I mean for the special duties that come to a doctor on a ship.

REAR ADMIRAL WILLCUTTS: Our Reserve program, is such that our doctors are in daily practice and training because they are carrying on professional activities. They are not well trained, except the veterans, in preventive medicine, say, in amphibious warfare, for duty with the Marines in the field, with medical aspects of atomic bombs or bacteriological warfare or any of the special weapons. That is where we hope to emphasize training with our Naval Reserve medical officers -- in subjects other than clinical medicine that is so commonly thought of when you speak of a doctor. We feel that our Naval Reserve doctors who are graduates of Class A medical schools are sufficiently trained professionally. They do need to be alerted as we pick up special weapons, and especially in preventive medicine, sanitation, field medicine and amphibious warfare.

REAR ADMIRAL ANDERSON: How can training be given medical officers in our Service for staff duty? What I have in mind is that Naval medical officers on staff duty in the Pacific, particularly on the planning staffs, encountered many difficulties because of their lack of training in that kind of work.

REAR ADMIRAL WILLCUTTS: I used to marvel at Admiral Anderson's office in the fleet carrying on logistics for the most enormous flotilla of ships that was ever known. We had at one time 91 percent of the Navy in the Pacific. But there I think we must depend upon our Regular career men for staff work, for logistics, for

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USN 4 May 1948
2 CONTINUED:

that specialized form of Naval warfare. As a Reserve they don't get interested; they don't keep abreast, and they can't. They are too busy. From the knowledge of the last war we have doctors attached as students at the War College, at these logistic schools, and especially trained to take up this part of the strategy of the next war that our Reserve Naval medical officers could not possibly get without special inclination or special training for it.

REAR ADMIRAL ANDERSON: What training should we plan for enlisted men of the Medical Service in the Navy? I refer to enlisted men that are drafted or inducted during emergency.

REAR ADMIRAL WILLCUTTS: I think our Class A schools for enlisted men covered that very well. We have good schools on the East Coast, West Coast, Great Lakes. There subjects and basic sciences were stressed - first aid, laboratory, x-ray, and all those points. So I think within 6 or 8 months these youngsters can all be trained.

REAR ADMIRAL ANDERSON: Those are the Hospital Corps Training Schools.

REAR ADMIRAL WILLCUTTS: That's right.

REAR ADMIRAL ANDERSON: Your idea is that the hospital corpsmen can receive his preliminary training, military as well as technical, in those schools.

REAR ADMIRAL WILLCUTTS: That's right.

REAR ADMIRAL ANDERSON: It is not necessary to have special camps where they can be sent.

REAR ADMIRAL WILLCUTTS: I do not think so. Of course they all go through the training camps. They must be taught the fundamental of the sailor, and that, during the war, was cut down to a very few weeks; and then, depending upon the input and the demands, our Class A Schools turned these boys out in good fashion in a period often as low as four months. But we preferred the 6 to 8 month's course. At the moment it is cut down to 6 months, and then a 30 day period in our hospitals.

REAR ADMIRAL ANDERSON: Is there anything further on training? (no answer)

REAR ADMIRAL ANDERSON: This Committee is particularly interested in elements affecting the medical service in the combined force that must be accomplished now. Do you favor, in furtherance of your already expressed opinions, the establishment of some form of medical institute at some medical center composed of outstanding scientists, both service and civilian, which would principally gather the information of the past and that currently under investigation regarding military surgery, medicine, preventive medicine, atomic matters, and biological warfare matters; and further, could this institute give resident courses of various type to service personnel, civilian practitioners, and so forth, and further publish to the medical profession the results of their findings, including material for undergraduates, FMSTs, et cetera?

REAR ADMIRAL WILLCUTTS: I do definitely. That could be carried to the AMA conventions as an exhibit.

As Admiral Anderson said, you had this marvelous bulletin which we all used so much. Today we have this Navy News Letter. But again, it is not reviewing the things that should be reviewed.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILL MTS (MC) USN
4 MAY 1948, B CONTINUED:

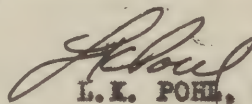
REAR ADMIRAL ANDERSON: This same question has come up with the Bureau, and I have the file. Their answer was that the Naval Medical Bulletin and the Medical News Letter form the means by which the Bureau publishes these technical details. But my idea is that it is scattered through the bulletins and they are isolated articles and concern details. They don't pick up the things that are needed practically by the men in the medical service very often. What is needed is something just like the Army Technical Bulletin, where the treatment of wounds, of extremities, and hearts, and so on is but a couple of pages so that you can sit down and read it and have the essentials. The same thing would be true for a thousand other conditions that the doctor meets. It would be a concise statement that includes the latest in concrete form -- injuries from atomic bombs and new things, and the old things, but put together not necessarily as a text book but as a bulletin, loose leaf, so it can be revised easily.

REAR ADMIRAL WILLCUTTS: Not as a book. I like the idea - old things. There are many old things we need to review.

REAR ADMIRAL ANDERSON: The bulk of it would be the things that are facts that have been long since established. No one man has got them all in his head. And when he gets to a particular section, he will have a reference that he can go to and get the dope.

REAR ADMIRAL WILLCUTTS: I think it could best put out medical subjects. Every war has brought out the fact that we have failed in malaria, in dysentery.

REAR ADMIRAL ANDERSON: It's a very wide field. The scientists and experts who are assigned to the institute or school, or whatever you call it, would be the people who would have to decide that.*****


L.K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA,
13 May 1948)

***** MAJOR GENERAL KENNER: "As to the next question -- professional and military emergency training programs within the Armed Forces -- I don't see why we should have any training for specialized doctors whose contemplated assignment presupposes the continued performance of their professional work. For instance, if you pull a noted surgeon into the Services and assign him as chief of a major surgical service, what training in the military sense should he need?

There should be comprehensive training for doctors to be assigned to tactical units basic with the medical department and tactical training units basic with the medical department and tactical training with troops in the field. I am just speaking of doctors."*****

***** BRIGADIER GENERAL MARTIN: I would like to ask you a question. In your experience, is there a need for an armed forces medical intelligence agency to establish and maintain on a current basis worldwide medical information that is so essential to planners for global war? If so, what organization seems most practical?

MAJOR GENERAL KENNER: I believe it is essential in long range planning to have a proper and current idea of the medical information, or morbidity situation, throughout the world. That may be accomplished by coordinating with two agencies -- one is the State Department where the Consular Service furnishes that information. However the consular fellow is usually not capable of evaluating a medical situation. The next would be probably as a branch of the M.I.A., or Military Intelligence -- to have a medical branch in that, or else under this thing I mentioned before set up as a section under medical research.

BRIGADIER GENERAL MARTIN: This Committee is particularly interested in elements affecting the medical service in the combined forces that must be accomplished now. Do you favor, in furtherance of your already expressed opinions, the establishment of some form of medical institute at some medical center composed of outstanding scientists, both service and civilian, which would principally gather the information of the past and that currently under investigation regarding military surgery, medicine, preventive medicine, atomic matters, and biological warfare matters; and further, could this institute give resident courses of various types to service personnel, civilian practitioners, and so forth, and further publish to the medical profession the results of their finds, including material for undergraduates, PMSTs, et cetera?

MAJOR GENERAL KENNER: I think there should be set up an agency such as you propose at the highest level; and I think, furthermore, that our Secretary of National Defense would be very remiss if, in the event of an

RESTRICTED

RESTRICTED

- 2 -

emergency, the public were not advised as to what measures they should know the effect of Gamma and other rays. They should know enough about the symptoms of certain biologicals to be able to protect themselves.

Is there anything else?"

RECORDER

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH BRIGADIER GENERAL JOSEPH E. BASTION, MC, USA
(RETIRED) ON 3 May 1948.

***** B. " This Committee is particularly interested in elements affecting the medical service in the combined forces that must be accomplished now. Do you favor the establishment of some form of medical institute at some medical center composed of outstanding scientists, both service and civilian, which would principally gather the information of the past and that currently under investigation regarding military surgery, medicine, preventive medicine, atomic matters, and biological warfare matters; and further could this institute give resident courses of various types to service personnel, civilian practitioners, and so forth, and further publish to the medical profession the results of their findings, including material for undergraduates, PMSAT's, et cetera?

BRIGADIER GENERAL BASTION: I certainly do. I don't know about (b) "Professional and military emergency training programs within the Armed Forces". Do you mean as applies right now, or when M-Day comes, or when?

BRIGADIER GENERAL MARTIN: We believe right now, before any actual calling to reduce the wastage from professional duties that is bound to occur if we wait until M-Day to bring doctors in and then begin to train them.

BRIGADIER GENERAL BASTION: You have to set that up, but that's going to take a while, and I should think the professional groups, AMA, and Dental Association, and so forth, the high "brass" in it should be made to understand this thing and start programs right away. There are certain things that they can teach in their every-day work.

As for the reserve, and so forth, I suppose that summer training will go on just the same. What I am trying to bring out, after hearing you, the only thing you can do right now is to make high people in the AMA, as I said, the dental associations, and all the other professional associations see the light and start programs right now, and I believe it can be done. It's going to mean an awful lot of work, but I don't think that the average person realizes what's going on at all.

I do think it's a professional thing, but I think it's neglected in that we don't emphasize it enough, and that is the preventive medicine or health teaching; for after all, if we can prevent these sporadic things that occur, even accidents, we don't need all these hospitals - that is, we don't need all the beds during the peacetime.*****

RECORDED
L. E. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

I. DISCUSSION

1. There is considerable variation of opinion in regard to assignment methods and much criticism of the overall medical personnel management as existed during and following World War II. Recommendations are made freely for assignment to duties best qualified to perform; for proper utilization of specialists; for centralized Medical Department personnel control and against such control; for firm rotation of hospital and field assignments; for permanent assignments so as to limit wastage resulting from frequent transfer between units; for age limit restrictions and more careful scrutiny of physical limitations which should restrict officer concerned to certain assignments; for utilization of interviewing boards to insure proper placement; for assignment in accordance with the individual's desire; for phasing of the assignment of skilled professional personnel to field units in accordance with their anticipated need therein; for and against the presence of many surgical specialists in forward areas; for avoidance of overstaffing; for the desirability of overstaffing to allow removal of Medical Department personnel from replacement pools; for assignments to reserve units of varying category for mobilization purposes; for and against assignment of non-medical officers (Medical Service Corps) to relieve the majority of professional personnel from other than purely professional duties; for desired policies relative to assignment and utilization of Regular professional personnel components; in regard to policies relative to rank and its relation to assignments; and for the Command level in which consultant services are deemed most desirable.

2. Rather uniform agreement exists that the overall consultant or specialist advisor utilization as Medical Staff members was successful during World War II and should be continued. It has been pointed out that there were instances of mal assignment resulting therefrom when employed in other than major command Medical Staff echelons; that such staff advisor requirements could be had frequently by utilizing individuals from nearby hospital organizations.

3. The joint use of civilian consultant and specialist advisors and teachers in Army, Navy and Air Force institutions was discussed and the following factors deemed pertinent for consideration:

a. In peacetime, the time that civilian consultants can be available to the military is on an average of two half-days per week. Where possible use is contemplated by two installations within reasonable distance of each other, the wasted travel time is a major factor. In view of such time limitations, generally speaking, the joint utilization of the same specialist consultant is not practical.

b. In wartime and in the case of recognized Military Professional Specialists, full co-utilization of such recognized specialists and consultants is more practical. This applies to Headquarters Staff, Hospital and Field consultant utilization.

RESTRICTED

RESTRICTED

It can be implemented in most instances by local arrangement and should be stimulated and planned for by highest echelon Medical personnel offices concerned.

4. The duty assignment of professionally trained officers merits the most careful consideration and should be predicated upon up-to-date classification as to training, previous experience and war-time capabilities and adaptabilities. The "numbers" or "bodies" method of assignments without proper previous classification is conducive to malassignment with resultant great wastage of effort and of medical manpower. Assignments as made and as they probably will continue to be made in event of another emergency may be classified into two main groups; those made on the basis of available classification data (often totally inadequate) and to fulfill a "number requirement".

5. The breakdown of assignment of Medical Department personnel as evolved from the last war was largely for a Staff consultant Medical Department Advisor to make recommendations for that purpose to the personnel branch concerned; Specialist Doctors by the Staff Specialists concerned; Dentists by the Dental Surgeon; Nurses and other female components by the Chief Nurse; Staff assignments as desired by the Chief Surgeon of the Command concerned.

6. The desirability of Regular Officers continuing in professional work in time of war with increased utilization of Reserve officers to be Commanding Officers is considered a sound policy by some. The main benefit to be derived therefrom, would be a more adequate supply of professional capable medical officers of the Regular components, upon demobilization.

7. The recent American Medical Association questionnaire (1947) revealed that from 20,001 Army replies, 4,751 (23.8%) felt they should have had and needed better assignments; of 5,727 Navy replies, 1,448 (26%) felt personnel could have been used more effectively by better assignments. Small percentages asked for less rigid methods of assignments and transfer, rotation of duties, assignment according to previous training, better assignment of doctors and replacement of non-efficient doctors. All comments (100%) made, referred to the same idea that the numbers of doctors in the service could be reduced. Also 100% favored the assignment of medical officers to purely professional duties. The questionnaire dealt with non-professional duty assignments and such usage of professional personnel. Nonprofessional duties, as described, included: Administrative, non-medical military, food and sanitation inspection, training of personnel and first aid.

The administrative group included administrative responsibilities, paper work, reports, Commanding Officer, Boards, Executive duties, medical and miscellaneous supplies, courts martial, inventories and property responsibility, records, welfare and recreation, censoring, mess officer or treasurer, hospital administration, auditing and financial duties, legal duties, duty watches and postal duties.

The non-medical military duties included: inspections, non-medical training, drills, tactics and maneuvers, hikes, lectures, marching, use and maintenance of weapons and equipment, gas and chemical warfare,

RESTRICTED

RESTRICTED

military construction, coding board and intelligence duties.

The food and sanitation group included: general sanitary inspection, kitchen and latrine inspection, inspection of buildings, wards, food inspection, medical inspection of personnel and insect control.

The training of personnel groups of duties included: Training of men in military duties, training of men in hospital and medical duties, first aid instruction, and physical training.

Finally, the first aid duties consisted of teaching first aid to various groups and minor laboratory duties.

8. To avoid malassignment and insure fullest use of most critical dental officer personnel and their assistants as well, their operational control in cellular units from Division or comparative Command high Headquarters appears most logical and was recommended.

II. CONCLUSIONS

1. That importance of proper duty assignment of professional Medical Department personnel cannot be overemphasized. Dissatisfaction with assignments may be considered one of the primary causes for dissatisfaction of the Medical Department professional personnel during the past war. There is no solution which will eliminate complaint and satisfy all, obviously, but policies and methods based on accurate classification data and the continuance of reliance upon the advice of the key professional advisor in the particular specialty involved is mandatory. Such individuals, in turn, should be top level from the beginning with full grasp of military requirements, psychological knowledge and ability in dealing with individuals, understanding and analytical judgment in estimating individual capability and above all honesty, both in premises as made and earnestness of effort to place individuals where they will be of most value to the military effort and yet in-sofar as it is possible where they wish to serve, and with adequate explanation when such is not possible.

2. That it is considered that some form of firm and just alternation of duty assignment for Medical Department personnel between combat, tactical, dispensary, physical examination center, and those more routine or less desirable professional positions with the preferable hospital and other duties presenting better professional advantages and opportunities, must be insured and carried out in the future to the maximum degree.

3. That in considering assignments in the military medical structure, the objective being primarily conservation of professional manpower, there is a consideration or concept of malassignment seemingly not touched upon in various comments received. It is deemed a fundamental consideration from the viewpoint of the primary mission and should be realized in the fullest spirit of service rendered to the country. It should be realized that no soldier or doctor or civilian, when his nation is at war, should object to the job assigned him if reasonable, reliable and honest making of such assignment has obtained. The viewpoint of expecting assignment solely in accordance with certain previous training and personal wish cannot be justified under the circumstances of war.

RESTRICTED

RESTRICTED

4. That consensus of opinion is for assignments based upon physical and mental capability, degree and type of previous training, in keeping with the job to be done. Where multiple capabilities for job assignment present, that which is to most benefit the war effort or any situation after the war is over, and not the individual, should prevail.

5. That majority of opinions received favor the criterion of professional capability for assignments, with rank consistent therewith. American Specialty Board membership is not considered to be the sole index to the recognition of specialists in the Services. That the consideration of a Military Surgeon Specialist classification as being contemplated by some, to provide an attraction for service on Staffs and with troops, is considered a most desirable step forward.

III. RECOMMENDATIONS

1. That a searching study be made by a joint armed forces medical body to establish the specific duties of questionable professional character which should be eliminated or retained as essential for performance by medical officers so as to enable the publication of a practical policy and guide on the proper command level that can be used in the employment of medical officers in peace and war.

2. That policy be established with periodic reemphasis to insure that all MSC officers will be assigned to nonmedical department duties by Commanders concerned only under most exceptional circumstances and in such instances only with approval of the local Senior Surgeon.

3. That action be taken to secure regulations in the Army and Air Force consonant with those in existence in the U.S. Navy which prohibit the assignment of all categories of enlisted medical personnel to duties other than those of the Medical Department.

4. That there be continued emphasis of present policies which utilize MSC officers to relieve professionally trained Medical Department officers of non-professional duties.

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Bascom L Wilson, Colonel, MC, Air Force, 21 April 1948)

*****Reference par 3(c)'General policies relative to assignment of Medical Personnel, including use of recognized specialists and consultants,' due to the apparent lack of far reaching plans in peace time, for the training of Medical and Dental officers for their war time assignments (with the exception of certain General and Station Hospitals sponsored by Medical Schools and Hospitals throughout the United States), these officers were not trained for the assignments received by them. As an example, many Medical and Dental officers were assigned at the last moment to various Air Groups and Squadrons and sent overseas immediately. Many of them had no previous experience with such units and were totally unprepared, and in many cases, physically unfit to cope with the situation. The emergency was so great that time was not available for proper selection of these officers. A large number of the Medical Officers assigned to these Tactical Units, had not been trained in Aviation Medicine. However, in most cases, they were willing, and accompanied these Units overseas, and did good jobs, only later to be replaced by officers who had been trained in this specialty (school training). By this time these officers, who altho they had not had the school training, but who had received their training in actual combat service and were well liked by their Commanders and other associates, were released to be replaced by these officers. This caused disappointment to the officers concerned and, in many cases, actual resentment by the Commanders of the Units. This situation was later alleviated to some extent by authorization to return the displaced officers to the United States for assignment to the School of Aviation Medicine for training in Aviation Medicine. While this was quite a help, it caused some disappointment and resentment among those who were not returned to the US as early as others. This could not be helped, however, for it depended on how soon replacements arrived. This whole thing could have been obviated had there been an adequate and well trained reserve of Medical Officers to call upon as soon as our mobilization started. Our Regular Army trained personnel is so small in comparison with our war needs, they can be counted on only to fill key positions in our organization, and we have to rely on the trained Reserves for the bulk of our needs."*****

***** During time of peace, a very carefully planned system of assignment of medical officer personnel, to the various types of Medical establishments should be formulated in order that when mobilization begins, personnel may be assigned according to their capabilities, specialties and physical fitness. Numerous instances were noted where officers, especially well qualified in some specialty, were assigned to Administrative positions; such instances as Obstetricians being sent overseas with Tactical Units. Many such officers continued on the mal-assignments without complaint, considering it patriotic duty, while many others secured proper assignments due to their continued efforts for same. Instances were noted in which older, almost elderly Dental Officers accompanied Tactical Units overseas. They were not physically able to stand up under field conditions and most of them were ultimately returned to the States thru the hospital route. The same may be said of many medical officers. I recall one instance in which a Medical Officer accompanied a detachment of casualties overseas. He was obviously physically unfit for overseas duty. He spent over six months in the Theatre, a large part of the time unassigned, and finally returned thru the hospital route. He was patriotic and wanted to go overseas, but a careful screening would have caught him before he departed the states and saved the government money and the officer much hardship and embarrassment."*****

RESTRICTED

L. K. POH
Colonel, MC

RESTRICTED

TRUE COPY (Extract Ltr Bascom L. Wilson, Colonel, MC, Air Force, 21 April 1948)

***** In reference to the lack of a well formed plan for assignment of Medical Department Officers overseas, it is obvious that the younger officers should be assigned to Tactical Units where the going will be rough and requires, in most instances, physical stamina beyond that of the average older man. In too many instances this was not done. Especially noted was the sending of officers overseas in a group of casuals, some specialists and some not. On arrival overseas, often there were no vacancies for the specialists, and they, as the non-specialists, were assigned to Units in a rather haphazard routine manner wherever an officer happened to be needed. This was most disappointing to the good officer who looked forward to an assignment where he could be of the most service to the government. Many of these finally found their way to assignments suitable to their experience and training, but many were shifted from pillar to post, resulting in many cases, in discontent, lack of interest, inefficiency and often in hospitalization and return to the States. In these times of Air travel, the need for specialists in overseas theatres should be accurately anticipated in order to send them over in increments as needed. The accumulation of large numbers of Medical Officers in overseas theatres prior to the time they are required causes a great loss of morale in those concerned. It all boils down to careful planning in peace for the requirements of war."*****

RECORDED

L. K. Pohl
L. K. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Letter from Colonel Richard T. Arnsst, Ret.
dated 19 April 48)

**** "c. Key personnel only ^{SHOULD} be assigned Medical Field Units such as evacuation and Surgical Hospitals, the same should apply to non-operating General and Station Hospitals. Medical Officers in theater reserve would be attached to such units as required when set up and operating. Nurses should be handled in a similar manner. Under this plan only a skeleton medical officer and nurse personnel would be assigned. Additional personnel required would be attached from the medical pool. (Actually few officers and nurses would be in this pool since the majority would already be attached to units that were closing.)" *****

RECORDED

L. K. Pohl

L. K. Pohl
Colonel, U. S. Army

TRUE COPY EXTRACT (Ltr Capt E.R. Hering(MC)USN, dtd 17 Dec 47)

***** C. "Lack of Senior Medical Officers trained in Navy and Marine Corps Staff Administrative work. This, in Captain W.T. Brown's opinion was our greatest need in the later stages of the war. I have seen time and again where a senior medical officer was assigned either to the Amphibious Forces or the Marines in a responsible position with the only qualification being his rank. The result was invariably that he had to take a back seat until he learned the job and by that time he was so disregarded by the Line and it was extremely difficult for him to get proper recognition for the medical and of the operation. The proper planning and coordinating of evacuation from an amphibious assault calls for an intimate knowledge of the facilities at your disposal and the capabilities of those facilities. Even with an adequate doctrine, it takes a forceful, well informed individual to push his demands through to conclusion in the face of a sometimes unsympathetic attitude to the part of Task Forces Commanders. Assignment of medical officers to the amphibious and landing force without due regard for the need of a high percentage of doctors with surgical experience. The surgery done in the forward area, either on the beach-head or afloat, is the surgery that saves lives and limbs and it is there that the best surgeons available to the Navy should be utilized. The assignment of a proper percentage of surgically trained personnel with the Amphibious Forces in actual engagements would be the responsibility of the Amphibious Medical Department in the Bureau as pointed out, above."*****

RESTRICTED

L. K. Pohl

E. E. POHL, Colonel, MC

180

RESTRICTED

TRUE COPY EXTRACT (Letter from Dr. Wm. G. Menninger, Topeka, Kansas,
dated 22 April 1948)

***** "(c) I would feel it was essential that we have to improve over the last war for the assignment of needed specialists in their specialty. Many, many times no attention was paid to a man's abilities and he was assigned wherever we needed a medical officer. We always justified it on the basis that a doctor ought to be a doctor first and a specialist second but actually this did not meet our needs and it certainly caused havoc in the morale of those many misassigned individuals.

Medical officers should never be assigned to duties which can be performed by an administrative officer.

Chiefs of Services and Commanding Officers of medical units and hospitals should be selected with much greater regard for:

- a. Professional knowledge
- b. Administrative ability
- c. Leadership qualifications.

Many times a man was selected in the last war purely on the basis of length of service and rank. As the result, many CO's were grossly incompetent, providing no effective leadership and were disastrous to morale as well as to medical practice. They tried to establish standards for surgery, medicine and neuropsychiatry and enforce them on clinicians who were far their superior as clinicians.*****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Albert T. Walker, Captain, MC, USN, 26 April 1948)

****"As regards the assignment of medical personnel including specialists and consultants, I believe that, except for key positions, this should be decentralized as much as possible. Medical officer assignment should be made by the medical officer on the Staff of the Unit Commander, such as a Fleet Surgeon, who is familiar with the problems in his particular area. This question, of course, is intimately associated with proper casualty care and hospitalization, and will be elaborated upon a little later."****

RECOMMENDATION

L. K. Pohl
L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Brig. Gen. Robert C. McDonald, MC, USA (Ret.)
dated 15 April 1948)

***** (c) General Policies Relative to Assignment of Medical Personnel, including use of recognized specialists and consultants.

"(1) Comment: In the early stages of W.W.II, technical medical personnel, both commissioned and enlisted, were often assigned to positions where their special qualifications could not be utilized to the best advantage. Many months passed before an effective plan for assigning specialists and consultants was implemented. Properly assigned medical specialists and consultants rendered invaluable service in establishing and maintaining a high standard of medical care and treatment. Timely classification of personnel is essential to giving specialists their proper assignments.

"(2) Suggestions: The assignment of medical personnel should be made in accordance with their primary qualifications. Specialists and consultants should be assigned so as best to supervise professional work in general hospitals and on medical staffs of territorial commands. Specialists at general hospitals may be used to supplement the work of consultants at various headquarters. The most used consultants at a headquarters are the Medical, Surgical, N.P., and Orthopedic." *****

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr M. C. Stayer, Major General, U. S. Army, Retired, 19 Apr 48)

****(c) General policies relative to assignment of medical personnel, including use of recognized specialists and consultants.

As a Theatre Surgeon in the Caribbean and in the Mediterranean, it has been my privilege to see the assignment and use of specialists and consultants. Many of the so-called specialists complained to me when they had been assigned to places and kept in positions which they believed could have been filled by others, although they were men of some years of experience in a specialty and were not being used properly. In handling a Theatre, it is my belief that consultants and specialists could be handled to a minimum, providing you can have units from medical schools, where you have many people who are well trained in the various specialties. I had the privilege of having two main consultants, and if I needed any other consultants, I produced them from the various units which were with me. I believe, in this way, there is much more incentive to do good work, problems are more easily solved, and decisions reached more quickly. Medical personnel arriving in a Theatre should be assigned as needed for particular positions after considering the advice of his consultants and executive." ****

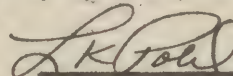
L. K. POHL
L K POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. C. Greaves (MC) USN
dated 17 April 1948)

***** "(c) Medical personnel should be detailed on the basis of obtaining the maximum benefit of their services. Overstaffing should be avoided as much as understaffing, perhaps more so, because too many persons on a particular job results in skylarking, lowered morale and neglect of details. A slight understaffing keeps people on their toes. They do not have time to skylark and their attentions are on the work all the time during working hours." *****



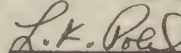
L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus, (MC) USN
dated 27 April 1948)

***** "(c) General policies relative to the assignment of medical personnel have been touched upon above. In addition it is believed that full advantage should be taken of recognized specialists and consultants and that these can best be employed at established centers for the care of certain types of war casualties. Amputation centers, neurosurgical centers, centers for the blind and for those who have lost their hearing, centers for tuberculous patients, centers for cord bladder cases, centers for the mentally disturbed, etc., fully equipped and manned by recognized specialists provide the means whereby the best possible medical care can be given. Equal facilities can not be provided in every general military hospital and it is considered that the best is none too good for the man serving his country in times of national emergency.

"Consultants such as those serving with the National Research Council and those who acted as special advisors to the Surgeon Generals (Army and Navy) during World War II, should be fully utilized." *****

RECORDER



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Quilton M. Sanger, BUMED, USN 15 April 1948)

****It was claimed there were not enough specialists in the Medical Department. The use of civilian hospitals for training in specialties for certification by Specialty Boards, was recommended to supplement naval hospital training.

It was proposed that civilian consultants be made available to each hospital approved for training programs and that a system of adequate remuneration be established. This was suggested as way whereby the Navy could use in peacetime the war experience of medical reserve officers separated from the service.

Hospitals should use Hospital Corps (Medical Service Corps) officers as administrative O.D.'s. This proposal fits in with criticisms mentioned in the previous memorandum regarding the undesirability of diverting medical officers from clinical to administrative work.

There was too rapid a turnover of H. C. personnel assigned to records offices. This contributed to the inaccuracy and incompleteness of medical records.

Hospital Corpsmen did many jobs that could have been done by civilians.

Coastal hospitals were all taxed to capacity and there was an inadequate number of corpsmen on duty during the earlier emergency period. The corpsmen were inadequately trained, and were put to work too quickly without hospital experience in some cases. Sometimes training was too general and not equated with the specific job to be done, especially in cases of corpsmen detailed to ship duty.****

RECORDER

L. K. Pohl
L. K. POHL
Colonel, MC.

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Quinton M. Sanger, BUMED, USN, 7 April 1948)

****It was proposed that when a medical officer is in the commander grade, certain ones should be selected for administrative duties and others should remain in the clinical group; and that there should be equal opportunities for promotion and pay for both groups.

CNO felt that medical officers should not be divided into administrative and professional officers. It claimed that officers of command rank engaged in exclusively administrative work were too divorced from the realities of field experience; and that this resulted in retarded or erroneous translation of field requirements into appropriate and effective administrative action. CNO favored rotation of duty.

It was proposed the medical commanding officers be furnished with administrative assistants trained in administrative procedures.

The prospect of training Medical Service Corps officers for a variety of administrative duties (supply, finance, records, budget, etc.) may be considered, as a way of enabling high rank medical officers to continue to pursue professional responsibilities at a high level.

It was recommended that a staff indoctrination school for selected staff corps officers to hold administrative positions should be established. Opponents of this proposal claimed it was an invitation to the Line to take over Medical Corps administrative responsibilities. This counterargument would not apply, however, to a proposal to establish such a school for Medical Service Corps officers in the Medical Department."****

L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel James H. Forsee, MC, USA, dated
20 April 1948)

******* (C) General Policy Relative to the Assignment of Medical Personnel
Including Use of Specialists and Consultants.**

It is easy to state that doctors, dentists, nurses, etc. should be assigned to duties which they are best qualified to perform. Unfortunately, the diversity of duties required of such personnel by the Armed Forces does not permit of perfection in this problem. In my opinion this was accomplished to a very satisfactory degree in World War II. Improvement should be strived for and can be accomplished. How to attain this objective is a difficult task and a few suggestions might be of some practical value. These are:

The designation and training of certain doctors for particular military positions whose specialty is not required in large numbers in the Armed Forces might be considered. For example, gynecologists, obstetricians, pediatricians, dermatologists, and many general practitioners could probably be more usefully employed as executive officers in large hospitals, as commanding officers of field and evacuation hospitals, and in certain staff positions. Such positions would offer these individuals an opportunity for advancement in rank which may not be readily available if they are retained in their professional specialty while in military service.

The whole problem of promotions based upon position vacancy discriminated appreciably against this group of personnel. Obstetricians unable to find proper professional assignment would still be permitted promotions to a higher rank. Many such officers are capable of carrying responsibility commensurate with increased rank, and such a plan permits of utilizing their services to a better advantage.

The present policy of utilizing recognized civilian specialists and consultants is a most valuable lesson learned from World War II and should and must be continued at the present time. One point is interposed at this time because I believe it merits consideration. It is as follows:

At the present time an attending staff member (consultant) is permitted to make 90 visits per year to our hospitals, at the rate of pay of \$60.00 per visit. Assuming that each visit averages 3 hours of time, which I believe is a probable reasonable estimate, the total time spent on these 90 visits is 270 hours for which he is paid \$4500.00. It is not easy to convince the young, able doctor that he should make a career in the military or naval service, and spend approximately 10 or 12 years to become a Major and receive an approximate annual income of \$4500.00. Assuming that a doctor in the

RESTRICTED

RESTRICTED

Armed Forces spends 10 hours a day, and I believe this is a conservative estimate, in the performance of his duties the attending staff member earns on this basis \$4500.00 for 27 days of duty. It is likewise not pleasing to those who have attained professional ability and recognition equal to many of the attending staff to note that their yearly income represents about 1½ months of the pay level of the attending staff members. It is recognized that such a pay level is adequate and necessary to attain proper attending staff members than it would be apparent that pay increases for our own Medical Corps personnel is overdue. It is my honest opinion that the Medical Officers of the Armed Forces are now receiving just about 50% of what the good doctors in the Service rightly earns. The poor doctor is overpaid regardless of his salary. To get and to keep good doctors under present economic conditions no method which does not provide adequate pay will be successful. Lets meet the issue squarely and obtain increased pay for all Medical and Dental Officers.

During World War II not a single regular Army officer was actually the consultant in medicine or surgery at an Army, Theatre, Corps Area or War Department level. It must be assumed that there were either no qualified officers or that other positions of administrative nature were more important. I do not believe that either of these assumptions are accurate. We had a few men qualified but too few. The reason for this deficiency was a lack of vision, planning and training of our surgeons, and internists for high professional tasks. The present residency program in our teaching hospitals will go far to alter this situation. We must not, however, stop here and the following proposal is submitted for consideration:

That 30% of the residents having the highest rating at the termination of their residency training be designated to attend various service schools of the line for a period of 6 months to 2 years. During this period they will become better acquainted and obtain a broader aspect of military problems than can be accomplished in an equal period of time by any other peace-time method. They will come in contact with the officers who will be in Command in times of war. Both groups will have a better mutual understanding of one another's problems and tolerance based upon knowledge will go far to dissolve some of the apparent difficulties encountered in times of war as well as peace which the Medical Department must face in presenting their problems to the General Staff. At the end of this period of instruction these officers should return to professional work. It

RESTRICTED

RESTRICTED

is not intended, and certainly not desired to suggest that civilian consultants should not be utilized in times of peace and war, quite the contrary is desired. Probably not more than 10 to 20% of all the consultants at these levels could or should be from the regular military establishments, however, officers of the regular establishments should and would greatly aid the civilian consultants in making the latter's task more easily accomplished during his military service." cccccc

L. K. Pohl

L. K. Pohl, Colonel, MG

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain H. D. Tompsten, MC, USN
dated 23 April 1948)

******* (G) GENERAL POLICIES RELATIVE TO ASSIGNMENT OF MEDICAL PERSONNEL,
INCLUDING USE OF RECOGNIZED SPECIALISTS AND CONSULTANTS.**

The assignment of medical personnel in general should coincide as nearly as possible with the professional qualifications of the individual, with due consideration of his physical stamina and endurance. Usually these qualities can be evaluated during the period of the individual's indoctrination and his reporting senior should provide the Bureau with a comprehensive appraisal of the officer's qualifications prior to transfer.

Young and inexperienced medical officers should be assigned to organizations where experienced seniors could supervise their activities and conduct their training.

Recognized specialists and consultants should be stationed at medical centers, preferably in the zone of the interior, where a training program can be conducted and their special talents utilized to the best advantage.

To my knowledge, there were very few instances of misassignment of medical personnel; many objected to being assigned sea duty, but in the vast majority of instances, the objections arose from their complete lack of knowledge of their duties aboard ship.*****

RESTRICTED

RECORDED

190

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel O. F. Mollnay, MC, Air Force
dated 20 April 1948)

***** "It will be noted that the undersigned is one of those who believes that, insofar as possible, professional personnel should be utilized for the accomplishment of the professional duties for which they are qualified and that such personnel should, in general, be freed from administrative and 'military' functions. In other words, it should be made possible for physicians and surgeons to be principally physicians and surgeons while in the military service."*****

***** "c. The assignment of medical personnel (professional) can be markedly improved. Much talent was wasted during World War II because of mal-assignment. No recognized specialists should be called into the service until there is an actual need for him in line with his specialty. He should be permitted to remain, providing service to his home community, until such a need exists. The number of such recognized specialists required by the services could be markedly reduced by permitting them to act as consultants to multiple medical facilities and through the rapid evacuation of patients to the Zone of Interior where large specializing medical facilities should be established." *****

RESTRICTED

191

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Earl Maxwell, MC, Air Force
dated 19 April 1948)

***** "4. There was a definite tendency to send enlisted men overseas who had gotten into trouble or were found worthless in medical installations in the United States. This was apparently less true of officer personnel. However, with the exception of affiliated units, the professional talent sent overseas with hospital units was inadequate. In my opinion more of the renowned specialists should have been sent overseas rather than remaining in the general hospital in the continental United States." *****

TRUE COPY EXTRACT (Letter, Captain J. H. Robbins, (MC) USN
dated 26 April 1948)

***** "Considerable confusion, at times causing actual embarrassment, existed throughout the entire area due to Bureau of Medicine and Surgery interfering with Force Medical Officers in assigning and detaching medical officers of the area without the knowledge of the Force Medical Officer. To overcome this, it is recommended that all medical officers be assigned to the Area Medical Officer for such disposition as he deems advisable, keeping the Bureau informed by copies of orders in case of any change and that the Bureau in turn process their changes through the Area Medical Officer." *****

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

**** "c. It should be the general policy to assign specialized medical personnel to positions in which their specialty will be taken advantage of, and only for cause should the classification of a specialist be changed. It is my belief that in general a Class A or nationally known specialist should be commissioned as a Colonel. A Class B or a specialist who is a Diplomate of the American Board and a Fellow of the American College commission as a Lt. Colonel. A Fellow or a Diplomate as a Major; also others who are well qualified because of experience and ability in a specialty. Those having no established specialty, but who have completed a recognized residency, should be commissioned as a Captain. A 1st Lt. in the Medical Corps should be eligible for promotion at any time after one year of active duty. Age limits for grades under that of Colonel should be adhered to in original appointments, not to restrict younger men, but to prevent the commissioning of an older man as a 1st Lt. or Captain, i.e. a Doctor or a Dentist 35 years of age should either be qualified for commission as a Major or above, or he should not be accepted." ****

TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee, dated 18 April 1948)

***** "(c) General policies relative to assignment of medical personnel, including use of recognized specialists and consultants.

"If a proper catalogue of available medical men by specialty, age, physical fitness, etc., is made in accordance with Paragraph (a) and if a proper T/O of all military establishments is drawn up, the one checked against the other would result in better assignments. In the zone of the interior, the hospitals should be largely staffed by older, part-time specialists who devote part of their time each day to service in military hospitals and part to civilian work and teaching. Military hospitals should be located near centers of population to make such personnel available. These older men are possessed of high skills and would welcome the chance for such service." *****

RECORDED

RESTRICTED

L. K. Pohl

193

L. K. Pohl, Colonel, MC

RESTRICTED

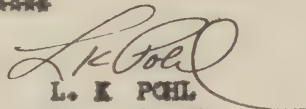
TRUE COPY (Extract Ltr Nellie Jane DeWitt, Captain (MC), USN, 29 April 1948)

*****A system for the assignment of nurses similar to that used by Army Nursing Personnel should be established. For example: The Bureau of Medicine and Surgery would have a pattern for a 25 to 100 bed dispensary, or a 500 to 1000 bed hospital. Sufficient nurses would be ordered to each District where they will be assigned as needed by the Commandant, upon recommendation of the District Medical Officer and Senior Nurse in the District. Such a procedure would provide better nursing care and preclude the possibility of an unequal-nurse-patient ratio.

Example: a 500 bed hospital needs a minimum of 50 nurses.

- 1 Chief Nurse
- 1 Assistant Chief Nurse
- 1 Anesthetist (nurse)
- 2 Operating room nurses
- 2 Dietitians
- 1 Instructor
- 2 Physiotherapists
- 2 Psychiatric nurses
- 1 Obstetrical nurse (if a dependents hospital)
- 37 ward nurses

50 TOTAL NUMBER OF NURSES *


L. K. POHL
Colonel, MC

RESTRICTED

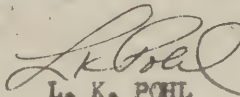
RESTRICTED

TRUE COPY (Extract from Ltr Alfred W. Eyer, Captain (MC), USN, 17 April 1948)

**** "(c) General policies relative to assignment of medical personnel, including use of recognized specialists and consultants.

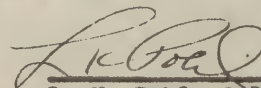
"It is not believed to be good policy to utilize specialist personnel in the front lines. Where combat conditions exist, working situations are apt to be highly fluid with little opportunity for the specialist to fully exercise his talents. Additionally, assignment of such personnel to individual units tends to violate the principles of conservation of medical personnel and effort due to the restricted numbers of service personnel coming under their cognizance. Assignment in base hospitals, hospital ships and continental hospitals is considered practicable.

"The utilization of civilian specialists and consultants in both peace time and war is considered highly desirable. It provides excellent training for service personnel; and, offers, on the part of both service and civilian doctors, an opportunity for appreciation of the outlook and problems of each group." ****


L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Colonel John A. Rogers, MC, USA (Ret.)
dated 19 April 1948)

***** "(C). General Policies relative to assignment of medical personnel, including use of recognized specialists and consultants. No comment on the consultant program which was excellent. It is believed that the utilization of specialists, as such, was in many instances carried too far. The services of many of these men were restricted to their specialty when they could have been utilized for duties outside of their specialty. It was my experience as Surgeon of the Fifty Army Area in Chicago, after the War, that this did not make for an effective utilization of manpower and somewhat hindered more rapid demobilization." *****


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

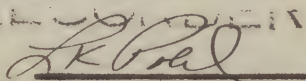
TRUE COPY EXTRACT (Letter, Colonel Robert E. Peyton, MC, USA
dated 19 April 1948)

*****5. Economy and Safety in Medical Plans and Operations. Let us face the hard fact that in the past war we possessed not only some skill but an inordinate amount of good luck. Uncontrollable epidemics of disease and blockage in the chain of evacuation from the theater to the zone of interior were ever-present potentialities which cannot now be forgotten merely because they did not materialize. All our reverses were temporary. We must face the fact that our combat troops had things pretty much their own way once they got rolling. Enemy capabilities to inflict higher casualty rates with new weapons and new techniques must be considered at all times. After the shooting is over and our hindsight becomes more acute, we are apt to engage in a type of "Sunday morning quarterbacking". Therein lies danger -- just because we had good luck before it does not follow that good luck is a national birthright and that we will have it again.

"National interest must be served by the utmost economy in the use of every medical officer. On the other hand, national interest and the common dictates of an enlightened humanity demand the highest standards of medical care for the men who fight our battles on the land, on the sea, and in the air. The mass of casualties will never adjust themselves exactly in number or in location to the medical means provided. In other words, just because we provide certain means it does not follow that the casualty load will stop when those means are exhausted. We must provide the means we feel to be safely sufficient to maintain the highest medical standards for peak loads of casualties in the constantly changing situation. To assume that either the civilian or military medical profession or the statisticians can ever predict with certainty the outcome of military operations and the exact requirements for medical means at the proper time and place is to endow them with a divine power which no one possesses. Reserves and flexibility for the medical service are just as essential as they are for combat troops. If we provide too little too late we assure a medical debacle and a national disaster. It is far worse to swing the pendulum from too much to too little. That every medical officer at all times be kept comfortably busy is in all respects an ideal situation not logically capable of fulfillment. We do not believe that every infantryman or anti-aircraft artilleryman can be kept busy at all times shooting his weapon at the enemy. All manpower will be in short supply. Further, if, due to slackening enemy resistance, we get by with less casualties than we had reason to expect, then there is cause to rejoice and thank Divine Providence for his mercy.

"The medical service is just part of a team engaged in a most supreme undertaking and we cannot gamble on its success any more than we can on the success of the armed forces as a whole. Safety is assured only by the physical presence of employable and adequate means within the theater of operations. In our eagerness to conserve critical medical manpower, let us take care that we do not fail to accomplish one of the major missions of the Medical Department - namely, the conservation of all military manpower. *****

RESTRICTED


L. K. Pehl, Colonel, MC

RESTRICTED


TRUE COPY EXTRACT (Letter, Colonel F. A. Blesse, MC, USA dated 19 April 1948)

****3. General Policies relative to assignment of medical personnel, including use of recognized specialists and consultants.

"a. The assignment of medical officers must be controlled at a higher level to avoid improper distribution. During the last war the combat divisions were usually below 50% of their authorized allowance of medical officers. Last minute additions were usually made at the Port and untrained officers were thrown in from the Service Command. Investigation showed that Service Commands and Air Corps had 100% of their authorized allotment during this period and they were at one time directed by G-1, W. D. (Gen. Henry) to immediately release a minimum of 400 to the Ground Forces for assignment to units preparing for overseas shipment. The Field Forces should at least have equal priority in assignments and consideration must be given to the fact that these officers cannot be qualified for field service without proper basic and unit training. They are needed early to also assist in the training of their own personnel. Complaints heard from battalion surgeons, for example, were that their professional training was wasted and that a sergeant could do their job as well. In every instance investigated, it was found that this opinion was based on a complete lack of understanding of the job due to a lack of proper training.

"b. As a policy officers over 40 years of age should not be assigned to combat divisions. Officers over 48 years of age should not be assigned in the army area behind the combat divisions. Officers who can serve in the ZI can serve in installations in the theater of operations, outside the army area, regardless of age or physical limitations. There were many instances during the last war where medical officers were classified as "limited service, ZI only". The physical impairment given as a reason for such classification was frequently some minor defect such as, chronic colitis, chronic sinusitis, chronic bronchitis, etc. These were so numerous as to cause frequent criticism and were a bad morale factor within the Corps. Service in a fixed installation in a Theater of Operations does not differ greatly from service in the ZI and as a policy, such limitation in assignment should not be tolerated.

"c. The records of reserve officers are usually not fully known to those making assignments. A system of records should be compiled showing briefly, the pertinent facts concerning prior service, training, qualifications and capabilities. These should be indexed in age brackets, specialties and likely assignments, and should be available for all those responsible for future assignments.



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT - Continued - Colonel F. A. Blesse, MC, USA

"d. Recognized specialists should be assigned direct to units where they are to function. There is little need for their military training and training in the few subjects considered essential can be given in addition to their normal duties as a specialist. Newly activated units could delay the assignment of such specialists until the latter part of their training period.

"e. The consultant program should be designed to furnish the Surgeon General with advice in specific fields of medical practice and administration. Consultants need not be limited to their own fields of interest in giving advice, but they should not be given authority that might prove embarrassing to the Surgeon General, the General Staff or the Secretary of Defense. It should be a fixed principle that each Surgeon General is responsible for the medical service of his own department, and that the consultants are merely to assist, within the general scope of their specialty, in the discharge of that responsibility. It is believed that this relationship between the services and the consultants can be established with tact and firmness, and it is essential to the prestige of military medicine that this be done.

"f. The duplication in assignment of consultants of various levels in a theater of operation is wasteful of this scarce category. Assignments as consultants in a theater should be at top level, at other levels they should normally not exceed one surgical and one medical consultant. If others are needed for special surveys, this can be accomplished by detail for temporary duty from a unit having such talent. ****"

RESTRICTED



L. K. Fohl, Colonel, MC

RESTRICTED

TRUE COPY (Extracts from Ltr Col. Harry G. Armstrong, MC, 16 April 1948)

**** "c. General Policies Relative to Assignment of Medical Personnel,
Including Use of Recognized Specialists and Consultants.

(1) Defects:

- (a) Specialists not used as specialists.
- (b) Regular Army personnel, no matter how well trained medically, given administrative work commensurate with their grades.
- (c) Failure of Command to properly evaluate medical service.
- (d) Ineffective use of highly trained personnel in small units.

(2) Remedies:

- (a) Keep specialists at their jobs or use only as consultants.
- (b) Indoctrinate Command with better concept of good medical care.
- (c) Indoctrinate civilian components to accept 3100 MOS's rather than that of a specialist."

RECORDED
L. K. PCHL
L. K. PCHL
Colonel, MC

RESTRICTED

RESTRICTEDTRUE COPY EXTRACT (Letter, Captain Lewis T. Dorgan (MC) USN)

***** "General Policies relative to assignment of medical personnel including use of recognized specialists and consultants.

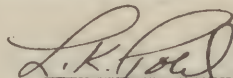
"During the last war it often occurred that after a careful distribution of medical officers within Seventh Fleet area so that each unit had its necessary specialists, orders would be received direct from the Bureau which would nullify all previous plans. An attempt was made to rotate doctors back to the States at the expiration of 18 months of foreign shore or sea duty but often Bureau orders would be received returning one man to the States after from 9 to 12 months outside duty which necessitated holding another doctor of the same unit for as long as 24 months.

"In global warfare only the personnel of a particular area can be cognizant of the peculiar personnel needs of that area. They should be free to move all doctors, and corpsmen within the operational area at local discretion. In the last war many medical officers spent idle months in pools ashore or uselessly rode LST's as surgical teams long after their ships had ceased to engage in amphibious landings. Seventh Fleet was cognizant of these excess medical officers but could not utilize them as they were under the administrative control of Central Pacific.

"Suggested Remedies:

"(1) Medical Department representatives of areas should submit personnel requirements monthly and needed personnel should be specifically ordered to within that area. They should all report to the area or Fleet Medical Officer for reassignment. All personnel declared excess within that area should be ordered out only by the local command.

"(2) Surgical teams and other specialized medical personnel should be used only temporarily aboard landing craft. As soon as their mission is accomplished they should be returned to a working pool, preferably one maintained at a large hospital such as the one established and maintained at Fleet Hospital 114 on Samar by Seventh Fleet." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED**TRUE COPY EXTRACT**(Letter, Captain O. B. Morrison, Jr., MC, USN
dated 23 April 1948)

***** "c. General policies relative to assignment of medical personnel, including use of recognized specialists and consultants.

Probably the greatest criticism of the Navy Medical Department was due to the assignment of well trained specialists to jobs having no relation to their specialty. Two examples which came under my observation will serve to illustrate:

A well trained obstetrician and gynecologist who had 14 years of successful practice in this specialty in a large city was called to active service, given a 6 weeks' course in psychiatry, and then ordered to duty as a psychiatrist in a large training center. The second case was an excellent young surgeon with 12 years in surgery, including post-graduate work at the Mayo Clinic, who was assigned duty with malarial control units and forced to do this type of work during the entire war. Obviously, the needs of the service are of paramount importance, but such assignments are sure to create resentment and discontent and are viewed by the individuals concerned as examples of pure arbitrary action which is foolish and inefficient.

A method used by the Tenth Army in Okinawa seems to be a good way to solve this problem of efficient assignment of medical personnel. A board of specialists consisting of a general surgeon, orthopedic surgeon, internist and psychiatrist were assigned to the army surgeon. This board was authorized to visit all medical activities in the area, to live and work in each of the hospitals until they made a thorough study of the needs of that activity. They individually interviewed and observed each medical officer and were given full authority to assign medical personnel in accordance with their experience and ability." *****

RESTRICTED

RECORDED



J. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter from Rear Admiral A. H. Dearing (MC), USN
dated 26 April 1948)

***** "(c) General policies relative to assignment of medical personnel, including use of recognized specialists and consultants.

During the campaign in the South Pacific area there was in my opinion too much centralization of authority for deployment of medical personnel in the Bureau of Personnel and BuMed at Washington. There appeared to be a reluctance on the part of the Navy Department, which was six thousand miles away, to allow the personnel officer of the staff of the South Pacific area to order personnel to duties where they were needed. To my knowledge no firm policy was ever enunciated regarding this matter. The writer, as Staff Medical Officer, utilized the authority of the Commander of the area to shift medical personnel as needed anywhere within the area and from ship to shore and vice versa. Personnel sometimes received conflicting orders from the Bureau of Personnel or from the Commander in Chief of the Pacific. It was only on protest by the Commander of the area that he was allowed to utilize his personnel as he wished. It is my opinion that in future planning there should be more decentralization of the authority from the Bureaus in Washington and that responsibility for personnel and its assignment within areas and districts should be delegated to the Commanders and Commandants of those particular areas.

There were too many "visiting firemen" coming into the area some of them merely as observers; others, presenting themselves as official representatives of the Bureaus and tending to divert officers from their duties and generally interfering more than doing any good within the area." *****

RESTRICTED

L. K. Pohl

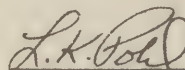
L. K. Pohl, Colonel, MC

202

RESTRICTEDTRUE COPY EXTRACT (Letter, T. F. Cooper, USN, dated 19 April 1948)

***** "Personnel planning had reached a high peak near the end of the war, and a great deal was being done toward utilization of medical manpower where the particular talents of the individual would count most. All medical officers were catalogued not only as to specialty, but as to their standing in their specialty. Information as to rank, length of service, marital status, etc. was also included. This was most helpful to those responsible for assignments. It is impossible, however, for all specialists to be continually occupied in their specialty during a war, and that should be thoroughly understood by all. In the terrific rush of mobilization during the last war, insufficient time and effort was expended for proper indoctrination of medical officers after induction. Too frequently the indoctrination consisted merely of assignment to a Naval Hospital for a short period where assignment to a ward and to the watch list was all too often all that was obtained in that direction."*****

***** "Assignment of personnel should be in accordance with the wishes of the individual, insofar as exigencies of the service will permit. Duty at sea or extra-continental stations should be terminated prior to or sharply on expiration of the usual or normal length of the tour and extensions should not be granted except under unusual circumstances. Undesirable billets should be rotated frequently. All officers should get a fair amount of hospital duty. Those showing outstanding ability should be given every opportunity for special training and advancement in their specialty. Utilization of recognized civilian specialists and consultants is a tremendous advance. It is stimulating to those in the service and is a means of stimulating the interest of the civilian profession in the armed services. By promoting interest and good will among the top men of the profession, medical officer procurement would be enhanced." *****



L. K. Pohl, Colonel, MC**RESTRICTED**

RESTRICTED

TRUE EXTRACT COPY

(Letter from Capt. Warwick T. Brown, (MC), USN
dated 20 April 1948)

***** "c. General Policies relative to Assignment of Medical Personnel, including use of recognized specialists and consultants.

In regard to field and amphibious medicine there should be a minimum of one surgeon with each Medical Company and with each platoon of the Corps Evacuation Hospitals. Each division should have a Psychiatrist and an Ophthalmologist. Each Transport which is designated to receive casualties should have a surgeon and each Transport Group should have an Ophthalmologist. Consultants to military organizations should be members of the Staff Section of the Senior Medical Officer of the organization in which they will function. They should have responsibility to instruct and coordinate practices in their specialty. Their personalities as well as their professional qualifications should be considered before appointment. They should if at all possible be members of the regular military establishment or carefully selected reserve specialists. They should be devoted to duty with the desire and a responsibility to lead and improve. *****

L. K. Pohl

L. K. Pohl
Colonel, U. S. Army

TRUE EXTRACT COPY (Letter, Col Robert P. Williams, MC, Surgeon, 16 Apr 48)

***** "c. General policies relative to assignment of medical personnel, including use of recognized specialists and consultants. Recognized specialists and consultants not to be called until a position vacancy exists. These people need but very little military training and should then be put to work in their specialty." *****

L. K. Pohl

L. K. POHL
Colonel, US Army

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Brig. General Roy C. Heflebower, USA (Ret.)
dated (undated) - received 30 April 1948)

***** "8. Quality of the personnel charged with training is another matter which deserves serious consideration. In the beginning the commanding officer of the Center was permitted to select and retain trainees to make up the authorized cadre. This not only permitted the selection of competent men but also permitted a highly desirable rotation of enlisted personnel. In other words, a commander could select and utilize the services of competent personnel for several months and then transfer the individuals to other commands and replace them with other men who had completed their training. The records of Camp Barkley show that as long as it was permitted this policy was followed and contributed to the efficiency of the Center and to the benefit of the units to which these highly trained men were ultimately sent. Later, the policy was changed and the only men available for the cadre were those considered to be unfit for overseas service. This resulted in the discards from other units of all arms being sent to the Training Center for utilization as trainers. Many of these men were non-commissioned officers who had no experience in the Medical Department, were not only of little or no value as trainers but absorbed the grades to which qualified and medically trained enlisted personnel were entitled.

18. In order to conserve medical officer personnel, I am inclined to believe more consideration should be given to the utilization of Medical Service Corps personnel in administrative positions in Medical establishments. The plan to utilize medical administrative corps personnel as Battalion Surgeon's Assistants during the recent war proved to be highly effective. These assistants were all trained at Camp Barkley, Texas. I see no reason why a Medical Service Corps officer cannot serve efficiently as an executive officer of a hospital. The commanding officer is always a medical officer, and in reality an executive officer is the administrator. The commanding officer could make decisions on purely professional matters and the executive officer could handle all nonprofessional administrative supervision. If there be objection to giving the title "executive officer" to a nonprofessional man, then the term "executive officer" could be dropped and "administrative officer" used in its stead." *****

RESTRICTED

RECORDED

205

L. K. Pehl

L. K. Pehl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 29 March 1943)

***** "(7) Some place in the shuffle we have to figure how to save medical personnel and use them more effectively. I think fundamentally this means that the Surgeon General has to have control of all medical personnel and there is no sense in the Air Force running hospitals that the Surgeon General's consultants can't visit; there is no point in having a lot of medical officers under the Ground Force that can't be touched and are kept out in the field as captains for two and three years without even a chance at rotation, etc. *****

***** "(9) In general, I am sure we should have much higher percentage of our psychiatrists in the field with divisions or field units or mental hygiene consultation services or outpatient clinics than we had in the last war. We had far too many in hospitals when I think we would have done a better job to emphasize preventive psychiatry." *****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Ltr Rear Adm F.L. Conklin (MC) USN, 27 Apr 43)

***** C. "Medical personnel should be assigned in accordance with their specialty. Consultants allocated for civilian billets could be used as consultants in our naval hospitals."*****

L. K. Pohl

L. K. POHL, Colonel, MC

RESTRICTED


RESTRICTED

TRUE COPY EXTRACT FROM AIR EVALUATION BOARD REPORT NO. 35. THE MEDICAL SUPPORT OF AIR WARFARE IN THE SOUTH AND SWPA FROM DEC 7, 1941 TO AUGUST 1945

***** C. "The efficiency of a unit was frequently closely related to the ability of the Flight Surgeon to obtain the confidence of the personnel in his command. Approximately 10 percent of the Flight Surgeons assigned to these theaters were unable to establish the mutual understanding necessary because of traits of personality and character which made them illfitted for this type of duty. It was difficult to assign such men as it was important that they not be assigned to positions where they might come in contact with flying personnel.

Approximately 10 percent of the Flight Surgeons assigned to these theaters lacked the personal attributes required for this type of duty.

There were insufficient Dental Officers assigned to the Air Forces in these theaters to maintain the dental health of Air Force troops."*****




L.K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

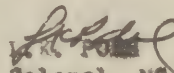
EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT HISTORICAL RECORDS OF WORLD WAR II. (Ltr. 13 Aug. 1943 fr. Brig. Genl Grant TAS to Col. Malcolm C. Grow, Surgeon, 8th AF)

***** "More or less in connection with the above, I have caused a survey to be made of all officers in the theaters from a strictly professional point of view. It is quite evident that the number of professionally qualified officers in service with out most active Air Forces overseas is considerably below the desired number. In the rush of expansion, the tendency has been numbers rather than quality. I think, for the future, that we have made a mistake in concentrating everything on the idea of the flight surgeon being a 'hail fellow well met', instead of a professionally qualified individual. To this end we are working toward seeing that every group has one man qualified in each of the following: Internal medicine, general surgery, ophthalmology, otolaryngology, and neuropsychiatry. Also, I think the tendency has been to use a very young age group, whereas it would be more desirable to have men of more mature judgment. The group of men now being sent to the School of Aviation Medicine fall into the category mentioned above."*****


L. K. Pohl, Colonel, MC

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS.


***** C. "Professional staleness, waning interest and morale, and the tendency to become self-satisfied in a smoothly working organization were encouraged by routine tasks which allowed the officer's surgical and other acquired skills to gradually fade through disuse. The duties and responsibilities delegated to many of them were so short of their abilities that the successful execution of them failed to generate any pride in the work."*****


Colonel, MC

TRUE EXTRACT COPY OF LTR CMDR M.T. MACKLIN (MC) USN DTD 12 May 48

***** C. "The recent establishment of the Medical Service Corps, should be the long awaited cure to the Medical Officers plague. The experienced capable men of the Hospital Corps, can now in their entitled position assume the administrative duties, Courts, Boards, Enlisted discipline etc., and thus permit the Medical Officers to perform their professional duties in a more efficient and conscientious manner."*****

RESTRICTED


L. K. POHL, Colonel, MC

208

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL HISTORY OF THE USAF IN THE MEDITERRANEAN THEATER
HISTORICAL SECTION - APTAS

***** C. "Although jurisdiction over assignment of all classes of medical personnel was essentially a function of the Air Force Surgeon, a large degree of latitude with regard to reassignment within the respective commands, after such action had been coordinated with the Office of the Air Surgeon, was found to be desirable."*****

L. E. Pohl
L. E. POHL, Colonel, MC

TRUE EXTRACT COPY (Ltr Brig. Gen. G.R. Kenneback, Dental Corps, dtd 7 May 48)

***** C. "The staffing of dental installations should be on the basis of not less than two (2) dental officers per 1,000 strength of individuals entitled to treatment. All jobs not requiring a dental degree should be filled by members of other Corps or by qualified enlisted men or civilians; thus assuring that dental officers will be employed full time on dental professional duties."*****

L. E. Pohl
L. E. POHL, Colonel, MC

TRUE EXTRACT COPY (Ltr Lt.Col W.J. Reuter, Dental Corps, dtd 11 May 48)

***** C. "Assignment of Staff Dental Officers - a. Deficiency - Table of Organization did not authorize staff dental officers in the early part of the war and many Air Forces suffered because they were not assigned. In some Air Forces their need was immediately recognized and they were assigned as overages until authorization for them was obtained on Manning Tables. In other Air Forces they were not assigned until 1944. The 14th Air Force apparently did not have a staff dental officer at any time. b. Unfavorable Effects - In the absence of staff dental officers, dental problems too frequently did not receive their due attention at Air Force headquarters in order to obtain effective and timely solutions. This was true particularly in the Pacific and China Theaters where the personnel shortage was critical almost throughout the war. Problems of station level were slow in reaching Air Force headquarters and dental officers at station level were denied the benefits of staff visits. c. Recommendations: That Tables of Organization of Air Force Commands, Air Force headquarters and higher Air Force Headquarters utilize in foreign theaters be authorized a staff dental officer for staff duty. Where staff duties do not require the services of a full time officer, this officer can provide the professional care of the headquarters personnel as well as an additional duty." *****

L. E. Pohl
L. E. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Arthur B. Welsh, MC, USA
dated 19 April 1948)

***** "c. Difficulties in control of air and ground medical service were created by the Army command structure. For example, a medical monitor was absent at topside to equitably distribute and assign personnel among major commands. It was chiefly a job of 'horse trading' in World War II -- and a difficult one at that. The Surgeon General was 'boxed' in Army Service Forces, had the responsibility, but couldn't exercise authority in many instances. There should have been more joint use of specialists and consultants." *****

TRUE COPY EXTRACT (Letter, Colonel Hervey B. Porter, MC, USAF
dated 23 April 1948)

***** "Lack of trained medical department personnel; individuals and unit, attached medical, arrived overseas who were evidently the culls of their home bases. Drunkards, perverts, and psychiatric cases were among such, which caused a heavy load on an already overtaxed medical who had anticipated the help of these same individuals in remedying the situation."*****

***** "c. The T/O assignment of medical personnel was too rigid. Too many units had no assigned medical, and would be dependent on a parent organization, such as a Service Center or Bomb Group for medical services. I have seen one dental officer responsible in this manner for the care of over 2300 men, and have seen one medical officer responsible for the health and sanitation of three fighter strips, fifty to three hundred miles apart in jungle area and only air communication between." *****

RESTRICTED

210

L. K. Pehl

L. K. Pehl, Colonel, MC

RESTRICTED

***** "General policies relative to assignment of medical personnel emphasizing use of recognized specialists and consultants - It is absolutely imperative that the Armed Forces be impressed with the fact that the medical service cannot be properly conducted without a wide use of specialists of all types and that these specialists must be given recognition in accordance with their age, and professional abilities. Therefore, it is essential that when bulk allotments are made for the entire forces in the grades from general officers down to the lower ranks that a special allotment of grades be made to the Medical Department. One of the greatest defects in the past war was that no provision had been made for the promotion of the deserving consultants and specialists. These officers had to compete with all other special and general staff officers for position vacancies in the higher grades. There was no T/O allotment for them and in consequence in many instances they were denied the promotion that they so richly deserved. It is essential in time of peace to prepare well-thought-out Tables of Organization for General Headquarters Medical Sections, Communications Zone Medical Section, Base Section Medical Sections, Army Headquarters Medical Sections and the like and that special Tables of Organization be prepared for consultant groups with ranks corresponding to their abilities and that these consultants be not placed in a position of competing with officers who are carrying out the vital tactical, administrative, and staff duties in the higher headquarters. The proper use of consultants is vital to the success of the Medical Department undertaking. This should be recognized and provisions should be made in advance for their utilization and assignment."*****

RE *L. E. Ford*
L. E. Ford
Colonel, MC

RESTRICTED

RESTRICTED

Extract of Statements made by Brig Gen Robert C. McDonald, MC, USA (Retired),
21 April 1948, before the Subcommittee on the Employment of Military Medical
Resources.

*****"Now, regarding "General Policies Relative to Assignment of Medical
Personnel, including use of recognized specialists and consultants."

"In the early stages of WW.II, technical medical personnel, both
commissioned and enlisted, were often assigned to positions where their
special qualifications could not be utilized to the best advantage. Many
months passed before an effective plan for assigning specialists and con-
sultants was implemented. Properly assigned medical specialists and consultants
rendered invaluable service in establishing and maintaining a high standard
of medical care and treatment. Timely classification of personnel is
essential to giving specialists their proper assignments."

Regarding the use of recognized specialists and consultants, I am
enthusiastically for it.

The medical consultants in my office when I was surgeon of the Fourth
Service Command were invaluable in maintaining a high standard of care and
treatment for the patients in our station regional and general hospitals.
They did a splendid job. They were well qualified. They were cooperative,
and I feel that they did particularly good work.

The most valuable of them, from my standpoint, were the internists, the
general surgeon, the neuropsychiatrist, and the orthopedic surgeon. We did
utilize brain surgeons, for example, and other specialists, but those were
not so much used, and when they were needed they could be taken from a
general hospital which was a center for their specialty, and the patients
could be taken to those particular hospitals. So we did very well on that,
and had the consultation service, plus the actual operating service at the
various specialist centers." *****

"What would you advise doing to prevent wastage of medical officers
during the training period of medical units?"

I would reduce the assignment of medical officers to units during the
training period in so far as practicable using administrative men in their
place for nonmedical duties. " *****

"How do you feel regarding the acceptance of lower mental grades of en-
listed men into the medical department? Should we take our proportionate
share of these types? If so, what assignments would you recommend for them?"

I think we can take our proportionate share of lower mental grades.
They can do janitor work and perhaps litter bearing and other tasks that do
not require a great deal of intelligence.

I would like to make a comment regarding the use of limited service
personnel by the medical department. I think we would have much less
difficulty in holding our men in the medical department if we could find

RESTRICTED

RESTRICTED

men that were limited service because of minor defects, who have special training in medical work, assigned to the medical department and no one else would want them.

I have heard that during the last war many of our units with medical sections with combat units were just taken out bodily and put into the combat units, because they needed able-bodied men. And, they traded us limited service men who didn't have the medical qualifications. So I believe that we should plan to utilize limited service men, insofar as practicable in the medical department, from the beginning, particularly in those positions where technical training is required.

"Do you consider it mandatory that once a soldier is accepted by the medical department that he not be transferred by staff action to other branches of service? How would you implement this authority? Did transfer of enlisted men affect the morale and efficiency in World War II?"

I would say that a physically qualified medical department soldier who has no special technical qualifications for the medical department might have to be transferred to the line under certain conditions. I don't believe that we can have an iron-bound rule on the general service man. Now, on the other hand, limited service men, I think, should be put in the medical department and retained there. Some medical department men desire transfer to one or other of the branches, perhaps in the interest of promotion or to a unit where his special qualifications may be best used.

"Do we need doctors in many of the positions we have used them in habitually, viz., executive officers, adjutants, registrars, supply, etc.?"

All medical units whose function is to care for or treat patients should be under command of a medical officer. But in large units, where the executive officer has sufficient work in administrative matters to do, without having to do any professional work, we can use other officers when there is a shortage of medical officers. Where there is a good supply of medical officers, I would prefer that the executive officer be a medical officer, because he has more control over the staff and better cooperation with them. The adjutant, I think, can be an administrative officer and need not be a medical officer, except in a special situation. Registrars are better if they are medical officers. But we can get by when there is a shortage of medical officers, by the use of administrative men. The same way with supply.

"In your opinion, should regular officers be given command of medical units and installations without regard to their administrative qualifications? Would Reserve officers acquit themselves as well? What is your solution to conditions where all regulars were removed from professional duties during World Wars I and II and as a result became deficient in medicine after those wars?"

I think that every medical unit should have an officer at the head of the hospital administratively qualified to carry on. That hasn't always been the case, not, of course, through the fault of the men they put in charge of units, but because we simply didn't have the trained men to put in command of the units.

RESTRICTED

RESTRICTED

Would Reserve officers acquit themselves as well? In many instances, yes. Generally speaking, almost as well.

As to the solution, I think it is unfortunate that highly trained professional Regulars should have to be taken off their professional duties. But I believe it was a matter of expediency. We just simply didn't have the officers to do the work; that was all.

I would like to see a highly trained medical specialist kept on his work in war, no matter what branch he belongs to.

"Should American Specialty Board membership be the sole index to the recognition of specialists? If not, would you suggest a basis for decision in this field by the Surgeon General's Office?"

I certainly don't think that Board membership should be the sole index of the recognition of specialists. I think that there must be some plan, or system, set up whereby we could verify the man's qualifications. A medical officer might be carried as a specialist by the American Specialty Board and not have practiced his specialty for some time. Generally speaking, I think that certification by a board is a legitimate evidence of qualifications, but not always.

"Did the consultant system work efficiently during the war? Did sectionalism have any part in their selection or assignments? How much did personalities play in the assignments by consultants? Did lack of general military knowledge of staff relationships play an important part in the disagreeable instances of command interference in assignment of specialists?"

My answer to the first part of that question—did the consultant system work effectively during the war—is that it did so far as I knew. It worked satisfactorily in my service command.

Sectionalism had nothing to do with the selection or assignment of consultants, so far as my experience goes.

I know of no instance where personalities played any important part in the assignment of consultants. It would be natural that it would happen, but I didn't know of it.

I have no comment on the last part of it.

"Are consultants necessary in each medical section headquarters from the field army on up? Can or cannot a generally surgical consultant handle all of the field of surgery?"

I think that medical consultants are required at section headquarters from the field army on up. They certainly worked to great advantage in the Zone of the Interior in World War II. I do not think a general surgical consultant can handle all the field of surgery in a large territorial command. I certainly think an orthopedic surgeon would be required, if you get in very many wounded. The general surgeon doesn't know enough about orthopedics to assure that the wounded get a high standard of care.

RESTRICTED

RESTRICTED

"In the civilian-consultant program now flourishing in our federal medical services, do you see why a single list recognized and available to all services should not be established as an economy measure?"

"Do you believe the accepted notion that troops respect and have confidence in their doctors as the result of their long association in training, through hardships, etc.? If not, do you consider withholding the assignment of medical officers in war to non-medical units until just prior to overseas movement?"

I don't believe that you should waste medical talent with units who are not in combat, when they don't need the medical care. I believe that a medical officer should be used in accordance with his qualifications and be kept busy. I do realize that it is important for members of combat units to know their doctor and to have confidence in him. I don't think it takes a long time to build this up through long association. I think a good personality on the part of the doctor can build this up in a matter of weeks."

L. K. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY:

(Extract of statements made by Colonel Thomas J. Hartford, MC, USA on 23 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

***** "c. Well, number 1, I think the present plan in all the services along career management is excellent if carried out, and of course they will be just as good as the people administering it and no better, but it's certainly a step in the right direction.

During peacetime in the assignment of reserve personnel I believe that has to be centralized to the services. As it now stands in the Army--I am speaking for the Army only--a certain number of reserve medical units are given to each Army as their responsibility and they have the reserve officers in their geographical limits, and frequently, even if they give the man the best possible assignment available within the Army area, the man still is not properly assigned.

I feel that we must get the information on our reserve officers, which we in the Army do not have, and the Adjutant General does not have, and once we get the information that we should assign them from, in our case, the Surgeon General's office, or from the Bureau of Medicine in the Navy.

I don't believe we should use doctors and physicians, that they are not needed if we have trained personnel to replace them; but I believe there are situations and positions in which you do need doctors, although they are not doing purely professional work. I think an executive officer of a general hospital may be a point in kind. I think that you will have a better hospital, especially if you are using a lot of civilian personnel, if the executive officer, for example, is a physician.

I also believe that we can get most of the highly-skilled professional personnel from the civilian pool during emergency, and that while certain regular officers probably should stay on professional work, and those obviously who can't do anything else shouldn't be put in administrative positions, but I think that a good many of them will have to do just the same as they did in this war regardless of any high and mighty plans we make to the contrary.

I think this question of consultants is important. I think it worked quite well in the last war. I think consultants are necessary in each medical section in the headquarters in the field on up, but I think they have to be limited, and I would say in the surgeon's office of the Army, for example, that a surgeon and medical

RESTRICTED

CONFIDENTIAL

RESTRICTED

***** "c. man and neuropsychiatrist is probably sufficient, unless you speak of the dental and veterinary officers as consultants in preventive medicine.

Relative to affiliated units, I think they are a desirable part of the organized reserve system. I believe the echelon-type of assignment to these units is feasible and ought to be looked into, and perhaps it should be a skeleton organization with only certain chiefs of service actually assigned, and that it be so called to duty.

I think that it would, might well do just that. In other words, if we replace medical officers by laymen in these key administrative positions and they all call for high rank, that eventually it will dawn on somebody that we are depriving promotion opportunities; that we already have reached that phase.

In other words, we all know that there can be just so many cardiologists, for example, or neuropsychiatrists, or anything else. We can use just so many in jobs that really call for the skill that we are educating them to have. There is going to be a group of people that we are trying to save them by calling it a new name, master physicians, or something, that are just general practitioners. Now, that group probably would look favorably towards some of these jobs that they could better fill, but now we are apologizing for the fact that occasionally a doctor has to do some administrative work, a small amount, apologizing for them and trying to tell them that they just won't have to do any of it the rest of their lives. *****

RECORDED

L. K. Pohl

L. K. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Captain W. D. Small, (MC), U. S. Navy,
dated 5 May 1948)

***** "3. There will probably be, as in the past war, more specialists than the Services can employ in their specialty. Recognized specialists and consultants are of inestimable value in training junior officers and a certain number can be utilized here. Recognized specialists must be the professional backbone of all major hospitals and in this post-war period consultants have amply demonstrated their value. The Army's system of specialized surgical, shock, and similar teams which were highly mobile and could be used to amplify professional services wherever needed was effective and the scheme in suitable modification could be employed thruout the Armed Forces. The Navy's epidemiological units were extremely valuable. Inevitably all doctors cannot be utilized where they would like to go and certain specialists must be employed outside their specialty. Adequate and early indoctrination in this respect may avoid many of the bitter remarks made about the past war.*****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 Apr 48.

***** G. "We had to assign large numbers of nurses to the transportation corps which was a new thing as far as assignment of nurses had been concerned, and it further depleted the number we had available for hospital duty. We know that, during the war and up to the present time, permanent assignment of nurse personnel to transport duty has been available. We would like to see it get back to our peacetime status or more nearly to our peacetime status where we depend upon our people transferring back and forth to take care of needs on transports, or probably it would be better to have one or two nurses assigned, and then depend on the additional needs for the nurses that are traveling back and forth -- have them travel to foreign stations and return, regulate that so that there will be available nurse personnel on all transports in officer travel duty status. Of course, transportation has been a different attitude regarding that, and they feel that they would like to have a full complement of nurses assigned to their ships.

In the transportation of nurses back and forth we have problems that, I think, could have been taken care of had the troop commander been in charge of all personnel on the ship. I don't know who was in charge, whether it was the captain or who it was. But Colonel Blanchfield had requested that the senior nurse be put in charge of the nurses. I know that the chief nurse who was assigned to the ship in some cases had suggested that she take charge of the nurses who were traveling, but she was told by her commanding officer that they had nothing to do with personnel traveling. We felt that somebody should have been definitely responsible for the personnel who were traveling for transfer to foreign theaters and return.

I might at this point, since I am talking about transportation, mention the quarters' situation on transports. We have felt that duty personnel assigned to transports should have suitable accommodations; that is, better than it was. But, again, I think they are beginning to have to double up. Their duty on a ship is most confining, and I think that they ought to have, as far as possible, the best accommodations that can be provided for duty personnel. I don't mean that nurses should have the best there is, but I think duty personnel on a ship should be given good quarters. We had many complaints from nurses in transit that proper accommodations were not supplied them as civilian personnel, war brides, and other groups were given preference to them who were in officer status and who insisted were in officer status. We were telling them of the type of person we wanted in the service because of their responsibilities, and they would come back and tell us, "Why aren't we treated as such?" I will say a little bit more about quarters later on. So much for transportation anyway.

In the program of returning the war brides, we used many nurses to assist with that program. We felt that this problem would recur again should we have another war on foreign soil, and that, when such personnel is returned, it would be better if they were first oriented; if they were oriented before they boarded a ship as to what to expect, because many of these women, I think, expected -- I don't know what they expected from the Americans -- but I think that, if they could be oriented as to what would be offered them in the way of medical service, care of their children, etc., it would have helped things.

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ABC, 27 Apr 48, CONT.

Necessary decentralization in matters of assignment of nursing personnel frequently resulted in the overstaffing of hospitals under the jurisdiction of one authority with resulting understaffing of one hospital in the near vicinity. I am thinking of hospitals that were general hospitals, the Class II installations which might be near a station hospital which was under the command of the commanding general of an Army, or a station hospital under the command of an Army with an Air Force installation nearby. When we assign personnel to the Army areas, to the Air Force, and to transportation, we don't touch that personnel again without concurrence from that service. When I was chief nurse in a station hospital, close by was a general hospital where our personnel policies could not always be kept the same. Sometimes I'd have much more personnel than the general hospital had, and we couldn't transfer it back and forth because we were under different jurisdiction.

I think that, if the Office of the Surgeon General could make the transfer on a temporary basis for the Army installations and Class II installations as the hospital needs require, such conditions might not exist. The surgeons of the commands have always been most cooperative, but I think the blockage would come probably through the personnel officers in the Armies and the Air Force because we really had no authority to transfer their personnel. People whose approval must be obtained in matters of personnel authorization sometimes, I think, have difficulty in understanding that the nursing service must operate a seven-day week, twenty-four-hour service and that, in matters of personnel assignment, patient load and bed authorization are not the only criteria upon which authorization for nursing personnel should be considered. Sufficient personnel should be authorized to allow the proper coverage of nursing service in matters of care of the patient in the bed and, in addition, the many assignments that we have to make to positions, such as anesthetists, administrative, supervisory, clinic, etc., which are not represented by beds.

BRIGADIER GENERAL MARTIN: What do you consider the most important step that should be taken now to prevent any of the serious mistakes that were made during the war in connection with wastage of nurse personnel?

COLONEL PHILLIPS: One of the things that, I think, the planning division is probably working on is a plan in calling personnel, to call them to active duty according to certain echelons so that we won't get all the groups on at one time and have them wait for a long period of time for shipment overseas. If we could bring our key personnel on duty and give them the necessary training and, when it comes closer to the time for shipment, bring the other groups on, I believe it would be helpful. We are certainly going to have to set up our basic training centers during war and get our newly appointed personnel, have them flow into those centers first before sending them to our general and station hospitals and trying to give them bit-by-bit orientation.

REAR ADMIRAL ANDERSON: As I understand, you feel that the Nurse Corps of the Army is so large that the assignment, distribution, equalization of the number in the staffs of various hospitals cannot well be handled in the Surgeon General's Office, that it is necessary to decentralize the personnel administration in that regard. Could you suggest how the difficulty in regard to distribution could be corrected if the assignments and transfers were handled by independent agencies?

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 Apr 1948, CONTINUED

COLONEL PHILLIPS: The Surgeon General's Office could go out to one of the Armies and say "Would you let us transfer nurses from this station hospital over to this general hospital on a temporary basis because we are short over here right now?" and let the surgeon do that without having to go through personnel channels. Let them handle assignments in the Medical Department. I think that would take care of some of it. We have a nurse out in each Army Headquarters; but, of course, they work with the surgeon who has charge of the medical service. The hospitals assign to the Army, not to the general hospitals.

BRIGADIER GENERAL MARTIN: What do you think the ratio of nurses to patients should be to insure proper coverage of nursing service and a reasonable work week?

COLONEL PHILLIPS: I think that, in order to compete with other hospitals and federal services, we must keep our personnel policies and standards on the level of the highest or the best civilian hospitals. The trend is toward a forty-hour week. Certainly, we should not have our nurse personnel working beyond a forty-eight-hour week. We should work toward reaching a forty-hour week, 3 eight-hour shifts. Where we are caring for large department services, we need additional personnel. My recommendation is at least one nurse to eight hospital beds. I think that, with that, we can cover the services that aren't represented by the patient in the bed, and put our people on an eight-hour day.***

RECORDED
L.H. POWELL, Colonel, MC

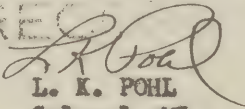
RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr W. H. Michael, Rear Admiral Retired, USN (MC),
19 April 1948)

**** * The assignment of regular senior medical personnel was reasonably satisfactory as was the assignment of senior reserves as chiefs of service within the United States. Many mistakes were made in the assignment of juniors, especially junior reserves because no qualification description was received with the officers. In the States sometimes it was possible to learn a man's background and make an intelligent assignment, but overseas a man's assignment had to be made immediately after - at the most - a few minutes talk with the man. My experience was that many, if not most, overestimated their ability in some speciality. A brief official resume' of every medical officer's background received with him would be most valuable in making assignments.

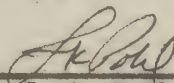
"Lastly, the rapid and -- to those in the field -- totally un-
explicable continuous change of duty of many officers contributed to
inefficiency in the Medical Department." ****


L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Brig. Gen. George R. Kennebeck, DC, Air Force
dated 7 May 1948)

***** * Qualifications of dental officers called to active duty during
a war should be carefully reviewed to insure that, so far as possible,
they can function in their specialty or in the branch of dentistry in
which they are most proficient. In general, this means that individuals
with the most civilian experience should be assigned to hospitals while
the younger officers should be on duty with tactical organizations.

"In the next emergency greater use of dental specialists and con-
sultants should be made. They should visit dental installations fre-
quently, at least three times a year, and remain at the stations long
enough to acquaint themselves with the problems existing and be able to
come to definite conclusions. In the past, these consultants have not
spent enough time at the stations they visited."*****


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** "As to age - up to the age of 36 I would recommend assignment to the ground forces, Navy afloat and combat groups of the Air Force. 36-45 years of age - service in medical bases overseas and in the interior. 45-55 civilian medical centers in ZI and civilian population.

"As to physical condition: Personnel with incapacitating defects should not come into the service. They should remain in civilian life subject to duty where needed.

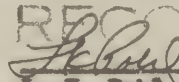
"Professional qualifications: Those with no specialty: up to 36 - combat forces, Army, Navy and Air Force. 36-45 - Military installations in ZI not requiring specialists, Army, Navy and Air Force. 45-55 - civilian institutions or localities in the U. S. not needing specialists.

"Situations requiring Specialists: Up to 36 - Army, Navy, Air Force units in combat zone and communication zone. 36-45 - Army, Navy, Air Force installations in ZI. 45 on - civilian institutions in the U. S. I think that with personnel in scarce categories there should be exceptions made.

"(C) 1. I don't believe we do, with the possible exception of the Executive Officer in General Hospitals. The reason I say that is that doctors resent a non-professional man.

"2. I do not believe regular medical officers should be given command of these units without regard to their qualifications. I believe that reserve officers would acquit themselves just as well if properly selected. This in effect is that if reserve officers are given command of units in accordance with their abilities both professional and administrative, they will release a great number of regular officers for upper echelons of staff duty for which they have more training."*****

***** "5. I think it would, as an overall rule. There are exceptions, of course. I believe sectionalism had an influence. Personalities played far too much part. I don't think that the specialists had sufficient military knowledge in administration for the things they did in matters of assignments, transfers, etc."*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E.R. HERING, JR., (MC) USN ON 20 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** C. "The third point, which you probably received from other sources also, is the lack of skilled medical talent in the forward areas available at the time of the greatest initial casualty load. This was true not only in the forces ashore, but was very marked in the forces afloat.

The first point I made was the lack of medical officers trained in staff work. I observed numerous times where a senior medical officer on a staff was assigned with the only qualification being his rank. Division surgeons who had no previous experience with the Marines were similarly put right in as a division surgeon; and the same way with the amphibious forces afloat.

I remember the APA that I was aboard didn't hit the beach until D-Plus-1, and we got 90 casualties aboard. We had one surgeon. Just to bring it home to you, there were six bellies in one operating room with one surgeon. There was just too much of a pile-up, and you couldn't get to them.

The general lack of skilled surgeons were so widespread that it is difficult to pick out any particular operation. However, I have one example which I think will prove this point. I received this information from Colonel Openheim at the 148th General Hospital. I stopped off there on a mounting out force for Okinawa. It's hearsay, but I have every reason to believe it's true.

He states that of the first 21 casualties that died at the 148th, following their evacuation from Iwo Jima, 16 of the cases were belly cases which had been operated on prior to reaching that Hospital. At autopsy, 15 of those cases had unclosed perforations, which is indicative of the type of surgery that was being done.

I consulted with Captain Galloway before coming up to ask him if he had anything that he would like to bring up; and he said that without any increase in personnel whatsoever, the 148th bed capacity was doubled and that the entire medical facilities of the Second Marine Division, which was bivouaced there in preparation for Okinawa, were turned over to them. At one time there were 172 cases awaiting surgery at that Hospital, a backlog of 172 cases.

For instance, in my organization now I am the surgeon in charge of all the Fleet Marines for the Atlantic. I am getting no Regular Officers to train. I am getting all W-12s. If we were forced to go in an operation today, I don't have one man who can do surgery. I have every hope that we would have these men ordered in. These men need training to operate in the field.

A Uniform Duty Classification for Officers of the Medical Departments of the Armed Forces. Such a system, in my opinion, is now an absolute necessity. It has one great drawback which may be overcome in its execution, and that is a man gets stuck in a particular classification or employment and has very little chance of bettering himself.

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E.R. HERING, JR., (MC) USN ON 22 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES, CONT.

I don't know how that worked out at higher levels, but I refer especially to our men in the war where the morale among our battalion surgeons was pretty sad. No matter how good a man he was, because of this T/O vacancy business, he was stuck there. He couldn't get promoted. He couldn't utilize his full facilities. If he was a good man, his commanding officer wouldn't let him go. There is a danger in a system like that. I think something must be put in so there is an elasticity or flexibility, where a man will not get stuck in a certain classification unless he rated it.

B. IGADIER GENERAL MARTIN: Wouldn't a policy of rotation, in your opinion, help to prevent that?

CAPTAIN HERING: Yes, I believe so. I don't know whether the Admiral (Admiral Adnerson) would agree that our Naval Medical Policy that a medical officer can do anything is certainly outmoded. I know I found myself in many situations where I just kept my fingers crossed and hoped nothing would happen, because I wasn't prepared, myself, to take care of it.

General policies relative to assignment of medical personnel, including use of recognized specialists and consultants.

There is one other point I would like to bring out in regard to this. I was tremendously impressed by the Army's system of consultants, and the caliber of those consultants, in the operations that I observed. I know that they raised the whole level of hospitalization treatment in the particular theatre which I observed them in. They had such men as Walter Martin, John Finney, Ben Baker, and other who were tops in their field. They would get right down to those people and say: "Look, you are not doing it right boys. You have got to handle them in this way. The shock has to be taken care of." And, they did it. The doctors in those hospitals appreciated that type of personnel coming to them and giving them that information. It was not only for the benefit of the casualty but for the benefit of the doctor himself. And, as far as I know, we had nothing like that.

REAR ADMIRAL ANDERSON: Would it be your idea to plan for consultants in other units than hospital units, under the Navy?

CAPTAIN HERING: Yes sir.

REAR ADMIRAL ANDERSON: You would have consultants in the amphibious forces.

CAPT HERING: That is a must. Right now nobody knows what kind of an outfit I have got. I inspect myself as being the FMF, Atlantic Force Surgeon; and I know what I have got as the best. Well, it isn't the best; it isn't the worst. But nobody knows how prepared I am -- what my capabilities are, what my limitations are, with the personnel that I have, whether I am doing a good job, or not. I would welcome inspection. It would raise the whole tenor. A man in the field, if he is any good at all, likes to be inspected. So it raises the morale of the whole thing, if somebody is paying attention to it.*****

RESTRICTED

RECORDED
L.K. POHL, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M. J. Aston (MC), USN
Fortsouth, Virginia, dated 23 April 1948)

***** "(c) General policies relative to assignment of medical personnel, including use of recognized specialists and consultants.

In the main, according to my observations and beliefs, such policies employed during the late war were realistic and practical. According to my observation it was usually found that the right man was sent to the right job. There were exceptions to this, but instances of this sort which came to my attention were very few. The policy of assigning young and active medical officers to duty with troops in the field was mainly adhered to and was a good one. Combat personnel of necessity must be young and vigorous. Sustained mental and physical hardships are not well endured by middle-aged or elderly officers and men. Instances of this are recalled. One such deals with a forty-five year old medical officer serving with Marines in the early days of the Guadalcanal campaign. This officer was received as a patient suffering from more or less complete physical and mental collapse. Only a short time previously he had been observed in quiet and peaceful surroundings and was considered to be a healthy stable and well ordered individual. The strain of a few days combat had effected very definite and serious changes. After his recovery had been established he attempted to explain his break-down in this manner. "The continuous noise of battle kept me keyed up at all times. I was unable to rest and during a lull in the firing I could not sleep yet the young fellows around me were able to put their heads against the soft side of a rock and go sound asleep."

During my services in the Pacific I observed the functioning of practically all of our hospitals in that area. I also knew most of the medical personnel of our forces afloat. I believe that the personnel of these units were properly assigned in the great majority of instances. Medical officer units at our hospitals represented well-balanced groups possessing the necessary and desirable professional qualities for such assignments. The same can be said for the hospital ships and hospital transports that came under my observation. In my own ship, The USS Solace, I began my service with a staff consisting of regular naval medical officers and three or four doctors of the naval reserve. All required specialists were represented in this group. In May of 1942 this group was replaced by a medical specialist unit from the University of Pennsylvania. They too represented a well-coordinated and well-trained group of doctors. It was the desire of these medical specialists units to remain together during their period of service. The hopes of all of them in this respect were not fully realized and as a result some feelings of disappointment and deep regret were expressed; however, I believe that it was necessary at times to utilize the services of one or more members of the units in situations that developed and where these services were urgently required. The needs

RESTRICTED

RESTRICTED

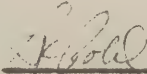
of the naval service in this respect should supersede the desires of the individual. Most of the griping and criticism I heard resulted from inactivity, and no doubt was engendered by an overwhelming and understandable desire on the part of the individual to get into the thick of things. I know of few instances where "race-horses were hitched to plows." Perhaps on occasion a highly specialized medical officer might bemoan the fact that he was serving in some other professional capacity and not doing the work of his speciality. Such few instances in my opinion were largely unavoidable and should not be given undue importance when the paramount needs of the services and of the conduct of the war are considered. It is to be expected that we can benefit by experience and commit fewer errors in the future.

In most of the Pacific areas with which I was familiar, recognized specialists were available if not readily available to all possible needs. The hospital and hospital ship staffs were well-balanced and included outstanding doctors. Such excellence was represented also in our forces afloat. Insofar as the assignment and deployment of recognized specialists to the hospitals and other medical facilities of the continental United States is concerned, it would seem that here too realistic and practical measures were employed.

During the mid-year of 1943 the navy began the employment of traveling consultants in the Pacific areas. This policy was not an expanded one and involved the use of a very limited number of medical officers. The army on the other hand employed these traveling consultants much more extensively. I think their use by the navy was of doubtful value except when sent to areas where experienced and well-trained medical personnel were not immediately available. The present policy of the Bureau of Medicine and Surgery which provides for the services of recognized specialists and consultants in all of our teaching hospitals and many of the others is considered to be highly desirable and one which will be of great benefit to our medical officer personnel as well as to our patients. Civilian influence on the future development of our Navy Medical Corps will perhaps become more apparent but this should be beneficial in all respects, provided that the fact we are maintaining Service hospitals with a singularity of purpose is not forgotten. Naval administrative control must not be relinquished.*****

RESTRICTED


227


L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert K. Simpson, USA (Ret.)
dated 1 May 1948)

*****"(c) General policies relative to assignment of medical personnel, including use of recognized specialists and consultants. In every instance qualified specialists should be assigned duties wherein their services could be utilized to the advantage of all concerned, regardless of "tables of organization", "position vacancies", etc. Mal-assignments of this nature were the source of lowered morale and discontent. For example, I found an exceptionally qualified plastic surgeon operating a small dispensary with a general hospital nearby badly in need of a plastic surgeon, a well trained maxillo-facial surgeon on duty with a squadron and the nearest general hospital without such a qualified officer, a diplomate of the American Board of ophthalmology on duty as assistant to base surgeon, etc."



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Robert M. Gillett (MC) USN
dated 15 April 1948)

***** "The assignment of medical personnel by too high echelon was one of the major errors of World War II. Better utilization could have been accomplished by permitting final assignment by Task Force, Area, or Group Commanders." *****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Dr. A. R. Shands, Jr. dated 20 April 1948)

***** "The assignment of medical personnel at the end of the war was quite good. One of my duties for the last 16 months in the Air Surgeon's Office was to be responsible for the assignment of all surgical personnel. In my opinion this was 98% the way it should be done." *****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. R. Urban (MC) USN dated 28 April 1948

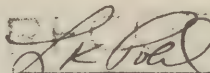
***** "(c) General policies relative to assignment of medical personnel, including use of recognized specialists and consultants.

"(1) Many medical officers, both Army and Navy, were used in sanitation and public health capacities that could well have been performed by sanitary technicians or sanitary engineers.

"(2) Too many professional personnel employed in purely administrative duties.

"(3) Professional staffs of medical units were too tightly tied to rest of unit. e.g. When a hospital is being held awaiting shipment or in reserve, professional staff were unemployed for long periods. (Both Army and Navy).

"(4) There was a lack of medical officers with joint operations experience and training. Recommend more use of available military schools for selected medical officers. (Naval War College, Armed Forces Staff College)." *****



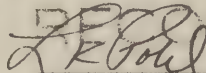
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain C. D. Middlestadt, (MC) USN
dated 17 April 1948)

***** "In reference to paragraph 3(c) of the committee on Medical and Hospital Services of the Armed Force letter, in the time of war I believe that all recognized specialists and consultants should be assigned to their specialties. There is no time to try to train these officers to be what we consider an all round naval medical officer. I personally know of one officer who had been doing tuberculosis work for several years. However, he was doing the work of a general practitioner for a year under me and his services were needed at the Naval Hospital, Corona, California. The Bureau of Medicine and Surgery ignored his request to continue in his specialty. I also know that there was a need for roentenologist and I know of some who were assigned to genito-urinary services or other services in which they had no interest. While these are only isolated cases, it is my opinion that it is bad for the morale. These officers will never help our program in obtaining reserve units. We promise them they will be able to practice their specialty and after they have signed up, they are then informed that they will be used where they are needed with no further consideration to our promises to them." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C. B. Camerer (MC), U.S.N.,
Retired dated 21 April 1948)

***** (c) Again in general as followed heretofore. However, while the assignment of highly specialized civilian consultants is most desirable, it is held they should NOT be assigned inspection duties, etc., ALONE, but with and under the direction of a Senior Regular Medical Officer, thereby avoiding inevitable friction, misunderstandings and unpleasantness, a frequent result of this practice of sending such consultants ALONE with Department orders to inspect and report on Service Medical Activities, with his impressions, etc., directly to the Bureau. While doubtless motivated by the highest ideals and objectives, this should be interdicted along the lines suggested.

"The assignment of highly specialized Reserve MO's to active Service Medical Centers in forward or advanced areas, hospital ships, and other vital Medical Activities, is considered most desirable and the necessity therefor is stressed. But they should ALWAYS be subordinate in rank to the S.M.O. of the activity concerned. Their services, properly distributed and assigned has heretofore and will in the future prove invaluable to the Medical Services." *****

RESTRICTED

L.R. Pohl
L.R. POHL, Colonel, MC

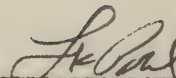
RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Emmett D. Hightower (MC), U. S. Navy
dated 21 April 1948)

***** "(c) In the general policy of assigning of medical personnel, an effort should be made to assign each person to the job for which he is best fitted. An example of improper assignment, is the case of an ENT&T specialist who was ordered on board ship as the only medical officer and he was not equipped to handle a simple appendix or other emergencies outside of his own specialty." *****

RESTRICTED

233

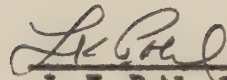


L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain W. C. Maty, Jr., (MC), USN
dated 19 April 1948)

***** "The establishment, at theater level, of the required number of special surgical teams, to be assigned to appropriate APA's for a specific operation on the bases of operational requirements. The practice of loading ships, other than hospital ships, to capacity with wounded, results in a backlog of urgent operative cases aboard these ships. It must be emphasized that wounded cannot be loaded aboard ship on a basis of space availability alone as supplies are loaded. Each ship's capacity to care for wounded must be measured in terms of available facilities and the skill of embarked medical personnel."



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY (Ltr Dr. H.S. Hoffman, dtd 13 May 48)

***** C. "Within the Continental Limits: In general, the Naval Medical Corps accomplished a reasonably good assignment of personnel to most establishments. In addition, more often than not, medical officers in command seemed pleased and even anxious to avail themselves of the special training and experience of recognized specialists detailed to their commands.

It is felt that thought should be given to certain present day trends in medical education and training which should have an important bearing on the problem of assignment of medical personnel in the future. World War II Reserve medical officers qualified in a specialty frequently questioned their assignment to duties for which they felt themselves unqualified. More often than not, the answer was "Son, in the Navy a doctor is a doctor - - even a pediatrician". On December 7, 1941, few if any officers of the Regular medical corps had not at some time in their careers done practically everything in the field of medicine and surgery. At the same time, among civilian doctors there was a growing number of men restricting their practice to narrow specialties who had had no experience in general practice previously. However, the great majority had a background of general practice. So, in spite of instances of errors in the assignment of personnel, the situation was not too critical. Practically the entire Regular corps and the great bulk of Reserves could adapt themselves to the exigencies of war by whatever the situation required. At the present time the picture is changing very rapidly. To practice in a specialty today it is essential to be certified by a Specialty Board. These boards almost universally require five years practice in the specialty before admission to examination by the Board. This practically insures that from now on doctors who become specialists will not get any experience in general practice. It is well known that at the present rate, specialists will soon outnumber general practitioners. In a few years we will have a large pool of civilian doctors qualified in medical specialties who will be as incapable of doing major surgery as any Line officer. With the very nature of combat creating the necessity for surgical procedures, this situation should, in a relatively short time, set up a nice problem for assignment officers. As a matter of fact, the Navy itself is contributing to this problem. As an inducement to young graduates to enter the Navy, they are being promised training that will qualify them to pass Specialty Boards. This program, if adhered to, can only result in an appreciable percentage of the doctors even in the Regular Corps not being qualified for assignment to general duty.*****

L. H. Pohl
L. H. POHL, COLONEL, MC

RESTRICTED

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic A. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

**** "No. 10. Yes, The best way I know to discourage a reserve officer, or the second best — the best one, of course, is to let him think it doesn't do any good to be a reserve officer — the second best way I know to discourage a reserve officer is not to assign him to anything. If our general reserve isn't large enough to accommodate—in other words, if the units that belong to what we call our general reserve aren't adequate to accommodate all the doctors, and they are not today, there aren't enough what we call T/C positions available in all our general reserve units to accommodate all the reserve doctors, then we should set up something else. We should set up composite groups, or what the Navy calls divisions, I believe, or something. This man must feel that he belongs to something, even though it means very little in the long run. He should feel that he belongs to a unit or an organization of some kind.

"As far as breaking up this assignment, that's not desirable, but it's necessary, of course, in a great many cases. The old idea of a mobilization assignment gave the man the idea that he was belonging to something and was going to be needed. The fact he didn't go there didn't hurt his morale too much, I don't think.

"I don't understand No. 11, relying on organized medicine to furnish medical officers for the services. I don't believe organized medicine furnishes doctors when they are drafted. I am not trying to quibble. Is that an implication that the AMA hit out people? I don't know. If it is, I am not prepared to answer the question.

"No. 12. That has to be answered both ways. If you have units, and if your unit is going to mean anything—I refer, for example, to an unaffiliated unit—the man have to be assigned in grades roughly commensurate with the table of organization grades.

"On the other hand, we are going to have other people, as I have just intimated—I hope we are—who belong to flexible units. These people should not be kept from promotion merely by virtue of the fact they don't belong to a particular unit, nor should people assigned to a unit be held in a position year after year after year, getting older and better qualified all the time and kept from promotion merely because they are in this vacancy. There should be some means for keeping this classification thing up to date, and then if a man is qualified for something else, either transfer him on paper into the other position, promoting him, or keeping our other units sufficiently flexible so he can be promoted on his professional ability."****



 L. E. Pohl, Colonel, MC
RESTRICTED

RESTRICTED**EXTRACT OF STATEMENTS MADE BY:**

Colonel Frederic J. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

***** "(c)1. I personally feel, contrary to some of my basic training, that we can use qualified—and I repeat the word qualified—non-doctor officers in a good many of the positions in which we have been accustomed to use them in the past and are still using them. I think when I say "qualified," I have covered it.

"The reason we have been using doctors so much in lieu of our former MAC's and what not, was largely due to the fact that the latter were not qualified to do the job. If we can build up our Medical Service Corps and/or if the Line or somebody can furnish us people that can do the jobs, I think they should do the jobs; but I think the Surgeon General should vote as to whether they are qualified to do the job, or not.

"(c)2. My answer is absolutely no. Just because an officer is a member of the Regular Establishment doesn't mean that without training he is qualified to command an institution. A doctor isn't trained to command a hospital any more than a grocer is trained to command a hospital. He has to learn to command a hospital. I think many of the criticisms that are being heaped on the Regular Establishment right now with reference to the failure of some of the regulars—I guess it happened more in the European theater—to handle hospitals properly was due to the fact that they had given these poor fellows professional-type experience in peace and all of a sudden said, "You are now a hospital commander," and you can't do that with anybody. Some people do any kind of a job without much of any preparation. Those are exceptional people. They are not average individuals at all.

"Brigadier General Martin: What is your answer to the preparing of regular officers for administrative positions during peacetime?

"Colonel Westervelt: I am glad you asked me that question. I will answer it by making a preliminary statement.

"I think first the decision should be made as to what we are going to do with our regular officers. If the bulk of the regular officers are going to, as in World War II, be required to take over the so-called operational activities of the medical department, then I think an ever-increasing and immediately increasing number of them should be given this type of training. If, as I heard expressed as an opinion of the front office the other day, we are not going to increase our proportions, but are going to expect a proper proportion of our reserve officers to come in and command hospitals and do our staff work, then arrangements should be made accordingly to train those people. That latter is practically impossible. You cannot at this day and age, with conditions as they are on the outside, expect a reserve officer to take administrative-type training, to leave his practice and take that type training. Therefore, regardless of any personal opinions, I think I would recommend that we immediately start replenishing our rapidly-dwindling corps of administratively-qualified Army medical officers."

RESTRICTED

RECORDED
Lehr
 L. K. Pohl, Colonel, MC

) continued 2.

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic A. Westervelt, MC, U.S.A. on 22 April 1948 at interview
with Subcommittee on the Employment of Military Medical Resources

***** " (J) 11. The answer is definitely yes. In only two operations which I had, medical consultants were considered part of the top staff and they were perfectly at home in every medical facility in the area regardless of who operated it, and they had authority to and did take immediate action on obvious local deficiencies, even to rearranging the physical layout of the unit, or something, if the efficiency could be increased thereby."*****

RECORDER

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

ABSTRACTED FROM PERSONAL LETTER TO COL. L.E. POHL, MC FROM COL. A. BARGQUIST, MC,
DATED 19 MAY 1948.

***** L. " The use of Regular Army Medical Officers in command positions, regardless of talent or ability to command, was one of the greatest factors in creating dissatisfaction among civilian doctors. We all remember many personal instances in which civilian doctors were embittered against the Army because of a moron commanding a hospital. The Surgeon General, in the future, should not allow jealousy of Regular Army prerogatives to prevent his appointing outstanding civilian doctors to command positions. You and I both know that fifty percent of regular doctors are not psychologically qualified or motivated as commanders. The same men, on the other hand, may be outstanding medical specialists.*****

L.E. Pohl
L.E. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL CORNELL, MC USA 30 APRIL 1948

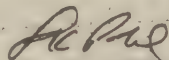
***** C. "General policies relative to assignment of medical personnel, including use of recognized specialists and consultants - Avoid overloading some units with men capable of leading sections in others. That is similar to the remark on strong and weak affiliated units. I think a strong skeleton could be built with vacancies for fillers. Then the affiliated units might yield two or more units where there is only one at present. And that idea has got to be sold to them right when they are organized, that they are going to get some men from other places, and that the whole unit cannot come from one school. I think if that is understood at the beginning there won't be the resentment of withdrawal of officers later on.

Specialists teams in reserve, if properly used, are of value. The use of the surgical teams in the last war were good examples when they were properly used. At first I think there was considerable resentment because the men in the units felt that the teams were coming up and getting the experience that they would like to have, but when they were used properly as help to a busy unit, then they are greatly appreciated, and I think such teams could well be used in other branches of work.

Too many consultants are a hindrance, especially when duplicated at all levels. I think it got a little bit to be the idea that because there was a consultant on this subject in the Surgeon General's office there should be a consultant on this subject in the theater, and therefore a consultant in the Army, and therefore the division needed a consultant on this subject, and we wasted medical men, and perhaps had too many ideas that weren't always practical.

That leads to my next remark; avoid too many "pet" ideas. They should be properly screened at a high level. While many good projects were under way at home and were recognized, the need was great overseas for men of that caliber. A large theater laboratory badly needed an experienced medical bacteriologist, but we could not procure one as all were engaged in the ZI on War Department projects. I was never able to get a bacteriologist of the caliber of the directors of my other divisions for pathology and chemistry; consequently, bacteriology was headed up by young men. I had good bacteriologists who were not medical officers, and I had a good young medical officer who was doing virus work, but none of them were of the caliber of the men like Janeway, Hudson, Francis, someone like that that we needed in that theater.

Avoid duplication of effort by circulating all procured knowledge. Ideas of the Fifth Army on trench foot were unknown in the ETO the next winter. I happened to have been in the ETO early in January and one of the first things asked me was: what are you doing for trench foot? And I was surprised to find out that they did not have the information which had been gained in Italy the winter before!



L. K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON B. WILLCUTTS (MC) USN
4 May 1948.

***** C. "This next subject refers to our policies relative to the assignment of medical personnel. I think that was included because there was complaint from individual medical officers here and there about being employed in certain kinds of medical work when they were specialists and qualified for other types of work.

REAR ADMIRAL WILLCUTTS: There again, I like our Naval Reserve program. By these divisions I spoke of, we are placing 75 medical officers to a division, with a number of nurses, enlisted men, medical service corps officers -- a component of each corps of our medical department.

We do not expect these divisions to be ordered out intact. If we had a division at Indianapolis, Indiana and 75 doctors of that division were ordered out, it might well impair Civil Defense materially. So we are listing our doctor reserves geographically in these divisions. We assign divisions right off the roster geographically, picking a good Reserve commanding officer and a good executive officer.

Our plans are that this commanding officer will simply be the titular head, so to speak, of this division. He will be in close liaison with the district medical officer and his reserve staff. There will be a very cordial relation so that if a national emergency comes up the district may, in close relation to these pools, find out what groups could be spared.

This divisional pool head probably would be a neuro surgeon. He will be encouraged and provided for, in this division, to have his nurse, his corporals, a complete neuro-surgical team. That team will be ordered out, and we hope that this team may maintain its identity with its division, with its parent division, to maintain its esprit de corps and recognition, and so on; and a satellite team will be ordered out, rotated back and forth as our Service needs may be. In that way I see no reason why a city or a zone would be depleted of their best doctors by having 50 doctors ordered out of some county. I would much prefer to pick from that division doctors who could go and then have, say, a year, come back to the division, and other members of the division go out on some rotation service so that civil medicine and the Service medicine would have a rotating service. I cannot ~~see~~ ^{see} why a good surgical team cannot be employed when a surgical team is needed, and then, if no casualties are among in, send them back home to their community subject to recall. As a member of this division carrying his colors, he wouldn't lose his identity.

REAR ADMIRAL ANDERSON: These Reserve officers would be called out by the commandant of the district.

REAR ADMIRAL WILLCUTTS: That is the mobilization program. At first it sounded terrible to me. But as you think it over, its not bad.

If they have this relationship, the commandant will be ordered from a central authority to produce so many doctors. Naturally the commandant is going to consult medically his medical staff. They in turn will have these division commanders, maybe 8 or 9 in his district, in close relation; and they could give what they can best spare from that community.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USN,
4 May 1948, 2.CONTINUED:

REAR ADMIRAL ANDERSON: The commandant will be informed, presumably,
from the Bureau of Medicine and Surgery.

REAR ADMIRAL WILLCUTTS: And also the commanding officers of the div-
isions cannot be expected to maintain a record system, a file system. He is too
busy. He cannot keep it, and you know that. So we don't expect him to keep an IBM
on his crowd. He knows them personally. All the records, all the professional cards
will be maintained by the commandant. So, if you want 10 surgeons, we know they
have got 10 surgeons out there.

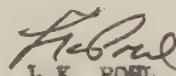
REAR ADMIRAL ANDERSON: And the commandant will be advised by the Bureau
of Medicine and Surgery of the need.

REAR ADMIRAL WILLCUTTS: Of the job analysis.

REAR ADMIRAL ANDERSON: That is, for certain specialties.

REAR ADMIRAL WILLCUTTS: That's right.

REAR ADMIRAL ANDERSON: Are there any further questions? (None)*****


L.K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA,
13 May 1948)

*****MAJOR GENERAL KENNER: "As to the next question -- general policies relative to assignment of medical personnel, including use of recognized specialists and consultants -- we have covered part of that.

I think we should discontinue the sponsored units as such. We should form teams of specialists and utilize consultants in higher staff work. I also believe that doctors carrying C and D MOS should be well assigned to field medical units, that is, having in mind your evacuation hospitals and field hospitals. I also believe that specially selected younger doctors should be attached to combat units or combat teams, having in mind there that they are limited in their application of their professional abilities due to the environment in which they operate and work.

REAR ADMIRAL ANDERSON: Is it necessary to call in a certain number of practitioners early in the training period, particularly with ground force units, for duty with those units, to consider the rapport considered essential, for the morale of those units when they reach combat, between doctor and patient?

MAJOR GENERAL KENNER: In my opinion the battalion surgeon is the most important officer in that unit. That is exemplified by remarks that have been made to me in both wars by line officers who have in World War I and II, for instance, asked by name for certain doctors. World War II Army, Corps and Division Commanders have told me that their field doctors were worth their weight in gold because they were the greatest morale factor within the unit -- that the knowledge that the soldier would have his medical officer with him when he got hit -- that he would not bleed to death, which seems to have been the greatest fear -- was of inestimable value. I believe, therefore, that upon the organization or activation of any line unit the medical officer should be immediately assigned and should have training with that unit they are going to serve.

I believe, furthermore, that in order to have those doctors available for such assignment, they must have completed the basic training in a medical service school and be earmarked so that we know who is going where and what he is going to do, what rank he is going to have, and be ready to immediately serve that line unit." *****

***** BRIGADIER GENERAL MARTIN: "There has been criticism that medical talent was wasted by the assignment of non-professional duties -- and that the table of organization should be modified so work of that kind can be done by non-professional personnel. Would such a modification, in your experience, have economized the number of medical officers necessary?

RESTRICTED

RESTRICTED

- 2 -

MAJOR GENERAL KENNER: Yes. I don't think there is any doubt but in many instances medical officers were doing work that didn't require medical officers. I have something on that later on." ***

RECORDED

Sub

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

D-1d. REPLACEMENT POOLS OF MEDICAL DEPARTMENT PERSONNEL

I. DISCUSSION

1. The inactivity of Medical Department officers while assigned to replacement pools was a great source of dissatisfaction during World War II.

2. Command or Line (non-medical) control of Medical Department personnel in Replacement Pools prevented desired information of Medical personnel from reaching responsible medical echelons and resulted in unnecessarily prolonged inactivity or misassignment of the Replacement pool Medical Department personnel concerned.

3. Utilization of high priority of air travel for transportation of all critical medical professional personnel at the time they are needed, will minimize the number of replacement concentrations of such personnel required, particularly of specialists. A suitable procedure for alerting, briefing and orientation before call to duty, and then active duty only when specifically needed, should suffice.

4. Medical Department replacement concentrations should be handled separately from non-medical replacement pools and under full control of the Medical Department at all times. It is believed that they should be operated if required, by any echelon beginning with or comparative to the Field Army, or higher. The provision of a Medical Department T/O and E for the purpose of establishing the administrative tasks connected with the transient personnel is most important.

5. In the event Medical Department personnel continue to be processed through replacement pools, a maximum time limit to restrict their continued retention therein should be enforced without question.

6. Replacement concentrations of Medical Department troops must be maintained and available for use by those responsible for supply of emergency replacements and medical coverage required and not foreseen by T/O assignment. It is believed that the Medical Department Replacement Pool establishment should include all personnel serving with that group and thus should include dentists, nurses, Medical Department enlisted personnel, etc. Avoidance of large pools of technically trained Medical Department enlisted men should be a guiding rule as otherwise the likelihood of their convenient removal from the Medical Department for training as combat troops is somewhat lessened.

7. The use of designated hospitals and medical educational centers for Medical Department replacement concentrations as temporary overstrengths is strongly advocated in lieu of combined service replacement pool procedures as followed in World War II.

II. CONCLUSION

1. That the supporting data on this subject is not extensive but should be entirely adequate for the purpose of this report. The reasons for the disadvantages of and the remedies to correct those deficiencies in Medical Department Replacement Pool operation as occurred in World War II are obvious.

RESTRICTED

RESTRICTED

2. That in the event of involvement of this country in another war, the likelihood of stagnation of medical and dental officers in replacement pools will be much less probably than occurred in World War II because improved procedures for procurement, better tables of organization due to experience in making up units required, and lessened numbers of doctors to be made available to the military forces, may be expected to obtain.

3. That fundamentally, medical echelon control of Medical Department personnel at the lowest possible responsible level usually the Field Army or comparable organization, will solve many of the deficiencies and disadvantages associated with operation of such necessary Replacement Pools for Medical Department personnel as may need to be established.

4. That the best method of utilization of Medical Department replacements prior to permanent assignment can be achieved by their allocation as temporary overstrengths to existing medical facilities.

III. RECOMMENDATIONS

1. That action be taken to insure that all Medical Department personnel in Replacement Pools are without delay made subject to assignment by the Medical echelon in the appropriate Command level, at all times in highest priority status for Medical and Dental officers, and utilizing the practice of temporary overstrength in existing Medical installations.

2. That assignment of officers to units should be made as soon as possible on an alert basis in event of emergency and that critical professional personnel be allowed to remain in civilian status until the last possible moment and then be moved to duty assignments by high air priority. That in order to enable this concept in practice definite representation for air means is imperative.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 22 April 1948)

***** "(d) Replacement Pools -- I never understood these. Many times I would get reports that physicians sat in these replacement pools for literally weeks on end without being assigned. Again, for reasons I never understood, they did not seem to be under the command of the Theater Surgeon and therefore he could not take men out despite the fact that he needed them. This was particularly true when we needed specialists. My impression is that there must have been some very serious mixup in the authority over the assignment of men out of these pools."*****

RECORDER

L. K. Pohl

L. K. Pohl, Colonel, MG

TRUE COPY EXTRACT (Ltr from Brig Gen Guy B. Denit, MG, Surgeon, dtd 16 Apr 48)

***** D. "Replacement pools of Medical Department personnel - Past experience has convinced me that replacement pools are deadly to the morale of any group for the reason that there are no T/O vacancies in the replacement pool to which officers may be promoted and that there has been and will always be a tendency to hold officers in these pools during long periods of time. In consequence they are and will be denied promotion or credit for service in a particular position or grade which seems to be necessary before a recommendation for promotion can be submitted. A plan for the creation of Medical Department concentration centers in which the T/O units are assembled is preferable. These centers may contain consultant teams, surgical teams, medical teams, and the like but all officers should, if possible, feel that they are a part of some organization even though that organization is not being currently utilized to full effectiveness. In this connection these concentration centers should be under the command of the Chief Surgeon, who should have the power to make transfers from unit to unit as the occasion demands."*****

L. K. Pohl
L. K. POHL
Colonel, MG

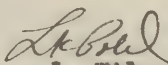
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Emmett D. Hightower (MC), U. S. Navy
dated 21 April 1948)


***** "(d) Replacement pools of Medical Department personnel are vital and necessary. However, they should be formed at major hospitals where the talents of the personnel can be utilized, and not formed at a Fleet or Force Headquarters or Receiving Station. An effort should be made to have all the various medical specialties represented in these pools." *****

TRUE COPY EXTRACT (Letter, Colonel Bascom L. Wilson, MC, Air Force
dated 21 April 1948)



L. K. Pohl, Colonel, MC

***** "Reference the system for release of officers and others after cessation of hostilities, apparently there was no definite system in existence at this time. It is probably true that the enormous demobilization of the Forces which began so shortly after the shooting was over, was not anticipated, however, whether or not it was, some definite plan should have been made prior to that time, flexible enough to apply to complete or partial demobilization. Not only plans for the actual release of personnel, but plans for the criteria for release and for those to remain in service during demobilization should have been in existence. The forever changing of criteria for release appeared to have a demoralizing effect on all concerned, even to this date in the case of Medical Department Officers. No one can fail to see that the release of those Medical and Dental Officers trained thru the ASTP Program, who had no active service, with no strings attached to them, was a great mistake. This is so evident now when the Armed Forces are so sorely in need of Medical and Dental Officers. Careful planning in anticipation of future needs of the services would have prevented this." *****



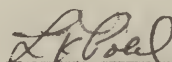
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert K. Simpson, USA (Ret.)
dated 1 May 1948)

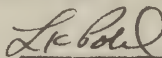
***** "(d) Replacement pools of Medical Department personnel. "Pools" as such should be abolished -- if at all practicable. General and station hospitals may absorb excess personnel and be used as a source of personnel for replacement purposes. Keep all individuals as active professionally as possible. The monotony and inactivity of being assigned to a "pool" or staging area adversely affects morale." *****



L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Col Robert P. Williams, MC, Surgeon, 16 Apr 1948)

***** "(d) Replacement pools of Medical Department personnel. Replacement pools are necessary. However with better staff planning and elimination of competition between the services it should be possible to alert doctors at their homes, then call them when they are actually needed. Planning will eliminate the justified criticism which has existed." *****



L.K. POHL, Colonel, MC

RESTRICTED

(d)

RESTRICTED

TRUE COPY EXTRACT (Letter, Nellie Jane DeWitt, Captain (MC) USN 29 April 1948)

***** "DEMOBILIZATION"

"Demobilization to follow the same pattern used after World War II, except that its progress should accommodate itself to the needs of the patient-load.

"The Bureau should keep each District or Area Senior Nurse advised of projected plans so that she will be better able to estimate her personnel needs and deploy the personnel. This also would apply to mobilization, casualty loads, and to demobilization activities. Much valuable personnel was lost unnecessarily in demobilization because nurses available for re-assignment were not returned to the States until maturity of demobilization points enabled forward area commanders to order them back under demobilization authorities." *****

TRUE COPY EXTRACT (Letter, T. F. Cooper, USN, dated 19 April 1948)

***** "Replacement pools in time of war are essential to meet the requirements of military and naval strategy. To the officer standing by in a replacement pool, it seems a tremendous waste of time and talent, and, therefore, much criticism arises. This criticism tends to snowball until one hears on 'very good authority' that 'there are several hundred officers languishing in the pool' when, in fact, there may be no more than ten or fifteen present. It is possible, too, to keep most of the pool officers busy on temporary assignments while awaiting permanent orders. With an alert assignment officer, replacement pools can be administered with eminent satisfaction. ComServPac administered a medical officer pool at Pearl Harbor during the late war without which medical service in the Pacific would have been greatly hampered." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Arthur B. Walsh, MC, USA
dated 19 April 1948)

***** "Zone of Interior Medical Department Replacement Pools were unduly criticised. Even though stagnation sometimes occurred therein, such pools were necessary to meet promptly the overseas demands and last minute requests for unit fillers. Had such pools not existed and had excess doctors been assigned to commands (air, ground, ASF) it would have been too difficult to 'extract' them to fill requests. This condition might have been corrected by providing The Surgeon General more control over all Medical Department personnel along with authority to cut across command channels. It took too much effort to shake doctors loose from the Air Forces, for example, but it was done frequently. Since commands were not permitted over-strengths it is difficult to visualize how they could function efficiently without the existence of pools. Theater surgeons didn't have but should have had pools for strategic placement within their commands and should have been permitted to dictate assignment of critical category personnel. Close harmony with the Theater Replacement Command in screening requisitions on the zone of interior and in interviewing and recommending assignment of replacements to positions within the theater was almost universally lacking overseas. It seems most necessary that theater surgeons should have this privilege since classification and proficiency rating is but an index to assignment and won't work without medical control of assignment." *****

TRUE COPY EXTRACT (Letter, Captain H. D. Templeton, MC, USN
dated 23 April 1948)

***** "(D) REPLACEMENT POOLS OF MEDICAL DEPARTMENT PERSONNEL.

"The desirability of a replacement pool was well recognized during the last war, and it would seem entirely feasible to maintain such a group of medical department personnel well forward in the zone of communication."*****

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

251

RESTRICTED

TRUE COPY (Extracts from Ltr Col. Harry G. Armstrong, MC, 16 April 1948)

**** "d. Replacement Pools of Medical Department Personnel.

(1) Defects:

- (a) Replacement pools wasted too much time.
- (b) Pools in general considered unsatisfactory.

(2) Remedies:

- (a) Better staff work, in that personnel called to duty when needed and not when convenient.
- (b) Pools in general considered unnecessary.
- (c) The use of pools and airplane travel to provide emergency service in special areas is justifiable."

RECORDED
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Robert M. Gillett (MC) USN
dated 15 April 1948)

***** "The use of 'medical pools' are too inaccessible and fosters discontent due to lack of employment. All types of personnel should have a definite assignment controlled by proper echelon. All types of personnel under this plan could have been gainfully employed in teaching, consultation, inspection, and educated in military problems, or at least kept busy, between actual combat assignments." *****

L. K. Pohl
RECORDED
L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Captain Lewis T. Dorgan, (MC) USN)

***** "(d) Replacement Pools of Medical Department Personnel
"A definite policy of rotation should be established and strictly adhered to in regards to forward and rear duty. As an area becomes inactive the medical department personnel should be withdrawn and re-assigned elsewhere without delay. The most marked cases of poor morale seen in the last war were among doctors in rear areas where there was not enough work to occupy their minds. Few men complained about their assignments for any reasonable specified period of time but at that time deadline was passed without definite word of relief, discouragement, listlessness, and dissatisfaction rapidly appeared and spread.

"Suggested Remedies:

"(1) Keep replacement pools and rear activity personnel at a minimum so that idle personnel would be few.

"(2) Rotate Medical Officers frequently from hazardous duty assignments." *****

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

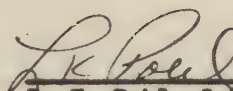
RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel O. F. McIlnay, MC, Air Force
dated 20 April 1948)

***** "d. Replacement pools of Medical Department personnel, insofar as they apply to physicians, surgeons, and nurses, should be kept to an absolute minimum and should be sufficient to meet emergency requirements only. Such personnel should in effect be taken into active service only as they are actually required. During a national emergency, all such personnel scheduled for mobilization should respond to a 'muster' which should be as local as possible, should have a physical examination, equipped with uniforms, and then, unless required by the services at that particular time, they should be returned to civilian life and permitted to serve their home communities unless their professional services are actually required, at which time they will then be ordered direct to the medical facility requiring their services. During the period of awaiting such such orders, they should be supplied with study material, aimed at preparing them to meet any new and unusual professional problems, such as those which might be encountered in atomic warfare or bacterial warfare, etc. Other Medical Department personnel should be kept out of replacement pools so far as possible and should be given intensive training in the manning and administration of various types of medical facilities so as to qualify them to handle all hospital administration, and thereby free professional personnel for professional duties." *****

RESTRICTED

254

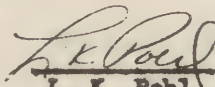


L. K. Pehl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. C. Greaves (MC) USN
dated 17 April 1948)

***** "(d) The maintenance of pools for medical, dental and nurse corps officers and corpsmen should be avoided as much as is practicable. We hear too many complaints from former members of the armed services that they were assigned to such pools for weeks and sometimes months, with no responsibilities except to report to some equally bored individual at stated intervals. To them military life means 'stand by to stand by'. It would seem that pools of this nature are justified only during the build up and early phases of a military operation. As soon as it becomes apparent that the operation is proceeding successfully the pool should be dispersed without delay. Planning Sections of the Medical Services should be kept informed of the implications calling for medical activities in all projected operations. This calls for closer integration of military and medical planning than existed during some phases of the recent war." *****



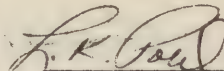
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain G. D. Middlestadt, (MC) USN
dated 17 April 1948)

***** "Relative to paragraph 3(d), my experience with replacement pools is limited to Samar - Leyte Area. The receiving ship pool was controlled by Service Force of Seventh Fleet. A junior medical captain assigned these men and looking from the opposite end, it appeared that he had no conception of the overall needs of the area. The Service Force Flag was often so far away that requests required weeks to pass through the chain of commands. At the same time I could not draw upon any of these men even in a temporary measure. Hospital Corpsmen whose services were needed in Fleet Hospital #114 were digging ditches or were on working parties in no way connected with the care of the sick and wounded. There was a G-4 hospital unit waiting on Samar for assignment. They had been waiting for over three months when I arrived. I made several attempts to have these officers assigned temporary orders in order to use their services. No action was taken until the fall of Japan. Then they were ordered there to process the prisoners of war. These officers were outstanding men at home, one being on the faculty of a medical college. They told me they had done nothing of a medical nature for almost a year. They were disgusted with the treatment they were given. Such conditions as these do not help our program in obtaining reserves."*****



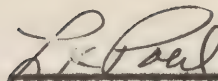
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED**TRUE COPY EXTRACT**(Letter, Captain O. B. Morrison, Jr., MC, USN
dated 23 April 1948)

***** "d. Replacement pools of Medical Department personnel.

Replacement pools are an absolute necessity, but it is the opinion of many observers that they were improperly used in the past war. To my knowledge, a large pool of medical officers and corpsmen spent nine months of an eighteen months' tour of overseas duty doing nothing but waiting for assignment. At the same time, combat units desperately needed replacements but could not utilize the personnel in this pool because authority for assignment rested with higher authority in the rear areas. It is my belief that medical officers who are sufficiently well qualified to be assigned as Task Force surgeons or Corps surgeons, and who are actively engaged in combat, should be capable of deciding how and when to utilize medical personnel in the replacement pools. " *****



L. K. Pohl, Colonel, MC**RESTRICTED**

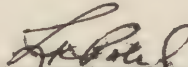
RESTRICTED

TRUE EXTRACT COPY:

(Letter from Colonel Richard T. Arnest, Ret.
dated 19 April 48)

***** "d. A strictly medical pool should be set up for each theater of a large base. Few of these officers would be idle since they would be attached to functioning units. As a front advanced all attached personnel would be released and reattached to a newly set up hospital unit. The theater or base surgeon would have complete control of this personnel in pool.

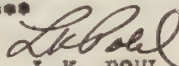
Consultants are essential though it is felt by me that one good surgeon and a good medical consultant for a theater, if not a large theater, would be sufficient. Specialists during World War II were occasionally wasted, however, the utilization of good specialists ^{was} inadequate. A good psychiatrist might cover several hospitals." *****



L. K. Pohl
Colonel, U. S. Army

TRUE COPY EXTRACT (Ltr Rear Adm F.L. Conklin (MC) USN, dtd 27 Apr 48)

***** D. "Reserve Medical Officers would be better than the Medical Divisions now being activated. *****



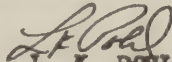
L.K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr James E. Hix, Lt. Col., MC, (Resigned) 11 April 1948)

****"Could be utilized on broader scale. As we had talked about in Italy, organize your hospital minus all professional components. When committed, professional components to be drawn from a pool in accordance with the mission."****



L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Brig. Gen. Robert C. McDonald, MC, USA (Ret.)
dated 15 April 1948)

**** "(d) Replacement Pools for Medical Department Personnel.

"(1) Comment: The establishment of replacement pools for Medical Department Personnel at certain general hospitals and at Medical Department technical training schools worked very satisfactorily during W.W. II.

"(2) Suggestions: The operation of Armed Forces Replacement Pools for Medical personnel should work well in next war." ****

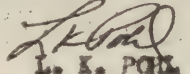

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Albert T. Walker, Captain, MC, USN, 26 April 1948)

****Replacement pools of Medical Department personnel as used during the last war resulted in a great deal of inactivity on the part of medical officers and was probably one of the most potent factors in generating dissatisfaction. Here again, decentralization should be practiced. It is most important for proper casualty care and epidemiological control to have recognized specialists in the forward areas, manning surgical teams and epidemiological control teams. It is in the forward areas where early definitive surgical care can best be given, that lives are saved. It is also true that epidemiological control measures must be instituted early in any campaign if the desired result is to be obtained. In this respect, it was found highly satisfactory in the Seventh Fleet, with which I am most familiar, to combine our malaria control and epidemiological control teams so that they could function together and continuously. Future plans should provide for mobile epidemiological control laboratories which can be dispatched on short notice from place to place as requirements demand. Properly constructed landing craft such as the LCI type of ship, with supplies and equipment, would make ideal mobile epidemiological and malaria control team and laboratory, including facilities necessary for shoreside transportation. They could then be spotted in as early as the day of a landing and commence the control measures which are so necessary for the success of any amphibious operation.****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY (Letter, Colonel James H. Forsee, MC, USA, 20 April 1948)

***** (D) Replacement Pools of Medical Department Personnel.

The functioning of Medical Department Replacement Pools in the Zone of the Interior may well be required to gear to a level of air travel. It may be feasible to think of overseas replacements in terms of functional units. In World War II transportation facilities and other requirements made it necessary to gradually concentrate large numbers of actually unemployed Medical Department personnel, especially doctors and nurses, etc. in overseas areas. This resulted in stringent criticism of the War Department by doctors. An Infantryman seldom complains of not being employed but doctors, nurses, etc. feel that long waiting periods, especially overseas, are unjustifiable. Transportation by air of even entire hospital staffs, that is doctors and nurses should warrant consideration. In one field, in particular, this seems most feasible and that is relative to surgical teams or units which function in forward areas. These surgical teams perform a highly specialized function in concentrating on the care of the most severely wounded. They are not needed during quiet periods but their demand is great and urgent during periods of heavy fighting. They work under very hazardous conditions and it was clearly demonstrated by both the British and our own experience that unduly long periods of such duty was highly undesirable. The organization and placing of such team units, on an emergency call basis from the Zone of the Interior with the employment of air transportation would make them available to overseas Theatre Surgeons when most needed and permit a system of rotation home which would improve morale and efficiency.*****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel R. E. Stone, MC (Res.) Air Force
dated 22 April 1948)

***** "Replacement pools are necessary but feel that the time spent by physicians and dentists at these stations should be reduced to a minimum. Was often told by men coming overseas how long they had laid around Replacement pools in the U. S. while there was a crying need for their services in the E.T.O." *****

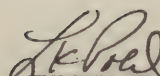
TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee dated 18 April 1948)

***** "(d) Replacement pools of Medical Department personnel.

"These 'pools' were all too frequently 'sink holes' where medical officers passed many useless weeks in stagnation. A proper bookkeeping system which showed where medical officers were and where they were needed would eliminate these foolish wasteful replacement pools. Medical men should be kept in their communities until they were really needed. (Remember the Marine men at Corona in the Navy in the past war?)." *****

RESTRICTED

262



L. K. Pohl, Colonel, MC

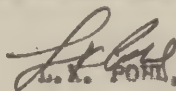
RESTRICTED

TRUE EXTRACT COPY (Ltr from Capt. Warwick T. Brown (MC) USM dtd 20 Apr 1948)

***** D. "Replacement Pools of Medical Department Personnel. Medical officers who have been trained for field and amphibious assignments should be earmarked for the forces for which they are trained. These officers should be ordered directly to the theater replacement pool."*****

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - APTAS.

***** D. "The need for casuats had been urgent for a long time. It became imperative during the last months of 1942 when a considerable number of medical officers and enlisted men were assigned to the Twelfth Air Force in order to complete the T/O for its various headquarters. Fortunately the situation was somewhat alleviated, but not entirely solved during 1943 by an apparent change of policy and a marked increase in Medical Department personnel. The Air Force Build-Up Plan of 1943-44 permitted a certain percentage of Medical Department personnel Section at Replacement Depots and assigned to units according to their qualifications. If not so interviewed, personnel forms and the recommendations of the surgeon of the Replacement Control Depot were used as a guide for assigning them either to the Eighth or Ninth Air Force, depending upon the respective requirements of each air force at the time."*****


L. E. FOWL, COLONEL, MC

RESTRICTED

RESTRICTED

Extract of Statements made by Brig Gen Robert C. McDonald, MC, USA (Retired),
21 April 1948, before the Subcommittee on the Employment of Military Medical
Resources.

****On the subject of "Replacement Pools for Medical Department Personnel,"
I agree that we should have replacement pools for Medical Department personnel,
but those replacement pools should be located so that special qualifications of
the personnel may be utilized in the interim while they are waiting.

I think that was fairly well handled in World War II. For example, the
Army Medical Center here was the big pool for medical officers. We had a large
pool at Lawson General Hospital in Atlanta. I think that we should have that well
developed, and time in the pool should be reduced to the minimum. The medical
personnel, particularly those that have special qualifications, don't do well
when they are held out of employment simply sitting around waiting for something
to happen. And too often they may be called upon to fill assignments which do
not require their special qualifications.

"Do you favor replacements pools of medical department personnel in each
echelon from the field army upwards? If so, how would you suggest administering
them to avoid wastage of personnel? Should they be a part of a replacement
depot or separate under medical department control? If under medical department
control, should we recreate a medical department T/O&E Unit for this purpose?"

I think that replacement pools should be territorial and not organizational.
I believe they should supply what organizations may be in their territory. I
think a great deal of medical personnel would be wasted if we established mul-
tiple pools. I think that a replacement pools should be at a medical installa-
tion, if possible, and under medical control.

I think the medical department should operate its own units. It certainly
worked well in World War II.

Brigadier General Martin: It didn't work well in World War II. A lot of
the disaffection we are hearing today was as a result of that personnel policy
which placed all replacements under G-1 control regardless of service.

Brigadier General McDonald: He might keep a record of what we have got.
But as far as controlling it, I don't think he should.

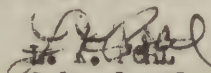
"Do you favor replacement pools of enlisted men of the medical department?
Nurses? MSG, etc.?"

Yes, I favor the establishment of those under medical control, and preferably
at medical installations for territorial areas.

"Should the Surgeon General establish pools at training camps for his needs?
Could we avoid that ~~and~~ in the ZI by a better system of calling medical officers
to duty? By alerting them in sufficient time?"

So far as an enlisted man is concerned, I think that is all right. I think
officers are better placed at some general hospital or medical installation where
they can be doing something. They should be left at home as long as possible."****

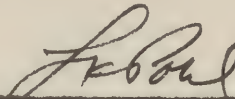
RESTRICTED


Colonel, MC

RESTRICTED

TRUE EXTRACT COPY: (Extract of statements made by Colonel Thomas J. Hartford, MC, USA on 23 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

***** "d. I think the number of people kept idle should be kept to a minimum, but there are administrative difficulties and I still believe that we should study and make every effort to properly utilize our human resources, but that pools may be necessary. Nobody has proved to me that they are not. I think they should certainly be kept to a minimum. Nobody likes them. Even the term "replacement depot" is a little repugnant to practically everyone. I think we must face reality that war is wasteful, and while that is not an excuse not to do anything about it, that we ought to obviate it as much as possible by calling the people just as late as we can and still have them trained to carry out their mission. *****



L. K. Pohl, MC
Colonel, U S Army

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Captain W. D. Small, (MC), U. S. Navy,
dated 5 May 1948)

***** "4. Replacement pools are a necessity but the personnel thereof should be properly employed while constituting such pools. If enough rapid transportation is available, a system of replacement pools stretching from the zone of the interior to advanced activities, pools to be located preferably in hospitals, could be set up where officers and men of required professional and physical capabilities could be progressively advanced from rear to front areas in the number and categories required."*****

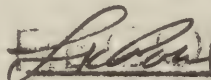
RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

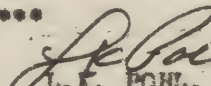
***** "(D) 1. I would be in favor of a Medical Department replacement pool separate from the depots now in the tables of organization of the Army.

"2. Yes. I think they could be included with the officer replacement pools and administered separately from the replacement depots."*****

 **ORDER**
L. K. Pohl, Colonel, MC

TRUE EXTRACT COPY (Ltr Brig. Gen. G.R. Kennebeck, Dental Corps, dtd 7 May 49)

***** D. "In my opinion, dental officers should not be assigned permanently to smaller organizations. More efficient operation is possible if all such officers available are pooled together and assigned to the headquarters of larger military organizations so that the staff dental officer could utilize them where they were most needed in his command. Dental officers should never be permanently assigned to the organizations as small as regiments, battalions, Air Force Wings or Air Force Groups." *****

 **ORDER**
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

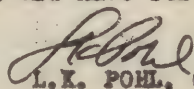
TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 Apr 48.

***** D. "The next problem was the holding of nurses in pools in staging areas. When I say nurses, this applies to all the women groups in the Medical Department. They were held for long periods of time in pools waiting shipment overseas, and then overseas in staging areas. That brought criticism from civilians and complaints from the nurses in hospitals in this country for both military and civilian hospitals were greatly in need of professional nursing personnel. The nurses overseas, not knowing the overall picture and the planning that was necessary, would write to their friends back home that the Army doesn't need nurses because they were held in pools. We had difficulty explaining to them that we couldn't move people in quickly; we had to do it by planning; we had to get them over there and have them ready in case of need; and it was a fine thing if we didn't need as many nurses as we had to plan for. However, all that damaged our procurement efforts.

REAR ADMIRAL ANDERSON: Do you have any questions that you would like to ask, General?

BRIGADIER GENERAL MARTIN: Yes. Colonel, you have criticized the replacement pool system as was operated during the World War. What is your recommendation to improve that system and still take care of the vacillating needs for nurses in theaters of operation?

COLONEL PHILLIPS: I don't know how. I really don't know the answer to it. We all felt that they were brought to the ports so far in advance of shipping. The transportation corps didn't know when shipping was available. I remember a group of nurses that was kept at the Charleston port for weeks when we were so short in the hospitals at home. Had the transportation corps been able to say, "Well, we can have a ship going at such and such a time that will accommodate women; get your personnel in, let's say --". Well, it would have to be longer than 72 hours during the war, I guess, but not make it weeks and months ahead of time. Now, I know the situation overseas. You had to get them over there; you had to get them overseas; and it was necessary for them, I suppose, to be in pools because hospitals were not set up. When I got over there, the war was just about ended. So I can't speak on what might have been done over there. But I do think that, here in the states, had we been able to hold them in our hospitals a little bit longer and sent them out closer to the time the ships were ready to leave, we would have had the benefit of their services here in the hospitals, and they would have felt a very real need for their services." *****


L.K. POHL, Colonel, MC

RESTRICTED

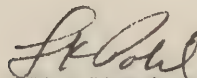
RESTRICTED

TRUE COPY EXTRACT

(Letter from Captain M. J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

***** "(d) Replacement pools of Medical Department personnel.

Certain of these pools were established in several strategic areas of the Pacific and they undoubtedly served a useful purpose inasmuch as members of this group were immediately available for emergency replacement purposes. Such pools should be located whenever possible in large hospitals or other medical centers where the professional services of these doctors can be utilized and where enforced idleness and inactivity can be held to a minimum. The morale factor here is important. A busy man has little time or inclination to indulge in carping criticism or unreasonable complaint." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr M. C. Stayer, Major General, U.S. Army, Retired, 19 Apr 48)

****(d) Replacement pools of Medical Department personnel.

My experience with replacement pools had to do only with all troops. I found the replacement pools very hesitant about giving up personnel. The Chief of the Medical Service should have authority to go into the replacement pools and take whatever medical men awaiting assignment he needs, notwithstanding the purpose for which they were sent to the Theatre. Sometimes they stayed for months, and nothing was done to send them to other places where they were needed."****

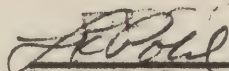
L K POHL
L K POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus, (MC) USN
dated 27 April 1948)

***** (d) It is believed that replacement pools of medical personnel would be highly desirable and that by maintaining such pools urgent replacements could be made without disrupting individuals and organized staffs already assigned to an established activity. For most effective administration and operational function personnel assigned to any given activity should not be moved except when due for normal rotation. Replacement pools would obviate the necessity for undue shifting of personnel. Replacement pools should be so located that educational and training facilities are available to fully and profitably occupy the time of personnel awaiting orders to active duty."*****



L. K. Pehl, Colonel, MC

RESTRICTED

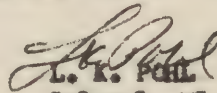
RESTRICTED

TRUE COPY (Extract from Ltr Alfred W. Eyer, Captain (MC), USN, 17 April 1948)

**** (d) Replacement Pools of Medical Department personnel.

"Replacement pools are not considered essential in the peacetime service organization where conditions are relatively stable and due consideration can be given to assignment. In wartime, however, they are believed to be quite essential in order to provide greater mobility and freedom of action for the forces in the field.

"Probably, one of the most pertinent factors relative to idle medical personnel in pools is the lack of decentralized authority to make shifts by local commands in accordance with their requirements. In the latter phases of the recent war, much was accomplished in such decentralization of authority with consequent smoother functioning. It is my impression that this did not apply in the early phases; particularly in the South and Southwest Pacific areas. *****


L. K. Paul
Colonel, MC

RESTRICTED

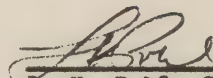
RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Earl Maxwell, MC, Air Force
dated 19 April 1948)

***** "10. In conclusion, every effort should be made to keep medical personnel occupied from the time they are taken into the service until they are released. Replacement pools had definitely a bad effect on the morale and it is believed a more efficient method might be utilized in the future."

RESTRICTED

273



L. K. Pohl, Colonel, MC

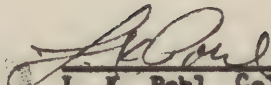
RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

**** "d. Replacement pools of Medical Department personnel should be maintained, but a short time limit should be established and personnel moved out rapidly, even though to temporary assignments." ****

RESTRICTED

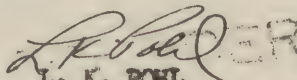
274


L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY (Extract from Ltr W. H. Michael, Rear Admiral (MC), USN Retired)

"Replacement pools of Medical Department personnel can best be made at hospitals - general, special, or field - utilizing the ones most convenient to the prospective need. The training under above paragraph (B) may be continued there. But assignments from the pool should be made by the Force Staff or District Medical Officer, not by the C. O. of the hospital." ****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral G. B. Cameron (MC), U.S.N.,
Retired dated 21 April 1948)

**** "(d) Again in general along the lines successfully pursued in World War II, influenced, of course, by existing Service needs and conditions, military aspects, etc., especially in more advanced areas. Medical Officers, as fast as primarily indoctrinated, should be assigned to hospitals or large concentration areas IN EXCESS of authorized complement in order to be always immediately available as replacements "up front" so their detachment would not occasion a critical situation in the activity from which withdrawn, thereby crippling the activity from which they are withdrawn, a regrettable occurrence I had occasion to note at different times during the progress of World War II." ****

REORDER

L. R. Pohl
L. R. POHL, Colonel, MC

RESTRICTED

RESTRICTED

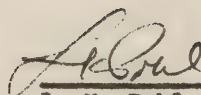
TRUE COPY EXTRACT (Letter, Captain R. F. Sledge (MC) USN
dated 26 April 1948)

***** (b) Replacement pools of Medical Department Personnel.

"Experience with pools of both Medical and Dental Officers and Hospital Corpsmen at Pearl Harbor emphasizes the importance of such pools. On numerous occasions it became necessary to replace or augment Officer and/or Corpsmen on very short notice and if such a pool had not been present neither replacements nor augmentation could have been effected. However personnel in the Pearl Harbor pool were not happy even though they were assigned to the area hospitals for duty while awaiting further assignment. Unhappiness became more pronounced if an individual remained in the pool too long especially if more recent arrivals were moved out in advance of his turn. Personnel had to be assigned not in accordance with seniority in the pool but in accordance with the specialty required.

"Pools should always be available to those responsible for emergency replacements. The pools should not be large, the personnel should not be allowed to remain too long, and they should be usefully employed insofar as possible." *****

RESTRICTED



277

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel F. A. Blesse, MC, USA dated 19 April 1948)

******4. Replacement pools of Medical Department personnel.**

"a. Replacement pools tend to become stagnant and are the source of numerous complaints. The need for pools of personnel is recognized but it would perhaps be an advantage to accomplish the same purpose by over-assignments at installations where some use can be made of their services during interim periods. The necessity for larger pools would probably be eliminated by a high level centralized control for all three services.

"b. There was considerable complaint received from hospital commanders regarding the excessive number of neuropsychiatric sent to them as medical replacements. Personnel boards acting on such cases, which have been marked fit for non-combat duty, sent too many such cases, to medical units for duty. This was perhaps due to the term 'non-combat' which was apparently associated with medical units. This reduced the efficiency of medical units to which they were assigned. Boards must be more thoroughly instructed as to capabilities of limited service personnel and their proper assignments.****"

RESTRICTED

RECORDED

L. K. Pohl

278

L. K. Pohl, Colonel, MC

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic S. Westervelt, MC, U.S.A., on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

**** "(D) 1. As far as officers are concerned, possibly this situation can never be reached, but we can approach complete elimination of replacement pools by proper calling in of officers and using those officers who are momentarily excess. In other words, those officers who are to replace tomorrow's casualties, and what not, by assigning them some place. Let's don't put them in a pool.

"One of the things that caused much of the disfeeling that we are having today among our reserve officers is the languishing presumably forgotten, and in many cases actually forgotten, in a pool. It happened not just to basic 3100s. It happened to C and B Grade specialists who were told they were so important they couldn't be sent home.

"I think if the Surgeon General can call for his doctors at approximately the proper time in the general scheme of things, and I think if the Zone of the Interior and then the theater and then the field Army—you can't go below that—surgeons can give these people something to do, let them belong to a unit just in the case of our reserve officers, I think we can at least tend toward eliminating these replacement pools. Whether we can completely eliminate them, I am not prepared to answer, but we certainly should reduce them to the absolute minimum.

"As far as their being part of a depot or separate medical department control, if a separate medical department control that is just that much more overhead we are going to have to assume, I would think we could operate a section of a pool just the same as we operate a section in a supply depot.

"Replacement pools of enlisted men probably are more necessary. I don't believe from my experience we can eliminate those. Units cannot mess and supply and bed down more than a certain number of individuals beyond their normal strength, and I believe in case of our enlisted men we would probably have to have pools. I feel, however, that no one should ever stay in a pool any longer than is absolutely necessary. "*****

RECORDED
 L. E. Fohl, Captain, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL CORNELL, MC, USA, 30 APRIL 1948

***** D. "The principal may be good, but many medical officers spent too long in them. Such officers would do much better attached to a unit as over-strength and held immediately available. Forward echelons always have vacancies for men so that some may be sent back for a rest and some fillers, instead of being in a pool, could gain valuable experience here. These men might better be left at civilian posts and alerted than to spend months in a pool. I won't expand on that. I am sure everyone has commented on it."*****

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS, (MC) USN
4 May 1948.

***** D. "REAR ADMIRAL WILLCUTTS: That, as I understand it, is that after they are once in the Service the replacements are casuals, so to speak. That is very important and necessary. That is where we get our criticisms perhaps, but it is necessary. You can't expect this so-called division that I just spoke of to take on the job of sending 10 doctors when needed. You must have replacements. War is wasteful, and it must be accepted by civil medicine. They know you have to have a reserve strength always. You might say that our checker playing champions are in excess in Washington. You may have them idle month after month. You may not have a fire for months, and yet you wouldn't say the fire department was not necessary. I approve of replacement pools. I think it is most important. But again, there, you must have them properly supervised. You must have an understanding that they don't get someplace as lost souls."*****



L. K. POHL, COLONEL, MC

RESTRICTED

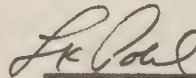
RESTRICTED

TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA,
13 May 1948)

MAJOR GENERAL KENNER: ***** "As to this next question -- replacement pools of medical department personnel -- I believe they should be so-called working pools established by overstaffing of medical units and installations with earmarking of personnel to be subsequently reassigned to other units to act -- in other words, as cadres, and so forth. Lists of such personnel should be maintained in superior headquarters by MOS and rank. In that way this Corps Area Surgeon -- we don't have those any more -- or Army Surgeon in the Army Area would have in his office a list of officers who, on call, would be immediately available for definitive assignment.

BRIGADIER GENERAL MARTIN: Should medical replacements in theatres of operations be removed from general replacement pool control and placed under the control of the surgeon of that theatre awaiting their definitive assignments?

MAJOR GENERAL KENNER: My greatest objection to the replacement depot was, one, that your medical officer loafed around with nothing to do. He became dissatisfied, his morale was lowered, and in some instances he was there for several months. Furthermore, the surgeon at top level was denied the utilization of his services during that period. The replacement system in its general administration was a pernicious system in so far as that pertained to medical officers. I believe, therefore, that all medical personnel within a major command or within a theatre of operations should be controlled by the senior surgeon of that organization, that he should have authority to overstaff by 50 percent, if necessary, any one of his units, considering that his overstaffing was in the nature of a pooling and that his officers, instead of loafing around, were being trained until such time as they were called up for reassignment, and that, furthermore, they were doing something useful." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH BRIG. GEN. JOSEPH E. BASTION, MC, USA (RETIRED)
ON 3 May 1948.

*****D. "Replacement pools of Medical Department personnel". As listed, and everything?

BRIGADIER GENERAL MARTIN: Yes.

BRIGADIER GENERAL BASTION: You ought to know that without anybody else telling about it.

BRIGADIER GENERAL MARTIN: Off the record.

BRIGADIER GENERAL BASTION: You will have to have something like that. I don't know what you will call it. That should be entirely understood by the medical people, and it should be very easy to run it.

BRIGADIER GENERAL MARTIN: As you remember the Medical Department had written into its organizational setup after World War I a medical concentration T/O unit. Do you favor a recreation of such a unit to avoid the difficulties encountered in World War II with replacement pools of medical personnel?

GENERAL

BRIGADIER/BASTION: Yes, I do, call it what you want to, but it's something which the medical should keep it filled and be responsible - I mean, all personnel should be used to the best advantage, and nobody else can say that but the medical high command.*****


L. E. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

D-1e. REDEPLOYMENT AND DEMOBILIZATION OF PERSONNEL

I. REDEPLOYMENT

a. General

The testimony and evidence secured in investigating this field proved that there was universal criticism of the system or lack of system in redeployment used in World War II, while next to nothing has been suggested to prevent many of the inequities of that practice. This is understandable when one considers the military events which transpired wherein one theater of war terminated hostilities in advance of another. This resulted in plans for transfer of the victorious troops and their facilities to another theater far distant and still engaged in a struggle whose end could not be foreseen. This may never happen again. Plans for redeployment between theaters cannot be made in peace but policies can be established which will alleviate many of the complaints and unfairness that resulted in the process used in World War II. Policies regarding redeployment and release from service of medical personnel for the zone of interior and for overseas theaters should be made as early as conditions of war permit. Once made, they should be rigidly adhered to without regard to the cries of the people or the medical profession.

b. Rotation of Individuals

(1) Civilian-Services

There has been considerable agitation towards consideration of a policy which would permit the rotation in a long war of medical personnel between civilian pursuits and the armed medical services. Theoretically, this appears to be sound and would certainly equalize the sacrifice incident to service. Practically, however, it has many serious drawbacks. First among these is the prior lack of knowledge of just when a war will terminate and hence when should an individual be rotated. The administrative part concerned with that type of rotation could be handled without too much effort. However, it is viewed, the efficiency of the medical services would be bound to deteriorate with each rotation. It would double the training requirements. Training facilities are important centers of manpower which should be used for combat as soon as possible. Such a premise denies the obvious fact that experience is a major factor in any individual's ability and therefore the efficiency of any unit he serves. Such a scheme for medical officers alone would certainly be discriminatory and suggest to avoid that unfairness that all personnel should be rotated periodically. This would certainly result in utter confusion and a prolongation of any war because of lack of efficiency. The main purpose of the military force is to defeat the enemy in the shortest time possible. Once an efficient fighting force is developed to defeat that enemy there can be no further reason which can justify the breaking up of that efficiency to satisfy the desires of its individuals. Therefore, the Committee believes that there should be no deviation from the practices of the past wherein only special cases were considered for relief from the service because of hardship or the specific needs of an individual in a key position in a civilian avocation. If the organized civilian medical profession forces this issue into law it must provide that every rotated doctor assume professional duties at once on his relief.

RESTRICTED

RESTRICTED

(2) Between Zone of Interior and Theaters of Operation

There was no special policy effective in World War II governing Medical Department officers in this field. They were rotated on temporary duty for rest and recuperation on a percentage basis along with all other officers and they did not like that system. In fact, no other officer category liked it but they were less vehement in their criticism. A great failure in the rotation system for rest and recuperation resulted when individuals rotated sought and succeeded in obtaining Zone of Interior assignments as soon as they arrived home. This led to the tightening up of the availability for rotation in units because of the shortages which ensued from the above practice. The accumulated disaffection was bound to affect the morale of all oldtimers on foreign service. It adds up to the conviction that a service policy once set should be rigidly adhered to or better never set in motion.

The rotation of assignments between Zone of Interior and Theaters of Operation in the case of medical officers was a haphazard one and when operative did much to cause resentment in the Theaters of Operation. The replacement of the rotated officer by one of the same rank stymied promotions, the goal of everyone. It was not operated on the first in, first out, principle because of lack of specialized knowledge to make adequate replacement without deterioration of unit efficiency. The point system whereby one was returned if he achieved sufficient credit worked an undue hardship on the overseas theaters because it failed to consider the need for the replacement of each individual. This was applicable to all officers but affected the medical services most adversely because of its varied specialized needs. Unless more direct control of Medical Department replacements is vested in the Surgeon Generals, there can be little done to avoid the errors of World War II, in the future. Present trends do not envision the decentralization of personnel management to the services, but it is believed continued effort toward that end for the Medical Department should be exerted.

More thought and action are needed to effect the rotation of specialists of the Medical Departments on a man for man exchange basis in war. This is considered a vital need to improve the knowledge of specialists in the entire field of their specialty and the whole medical service as well. Qualified men can be exchanged without loss of efficiency in this area. Plans therefore should be made in any future war to force this essential mechanism in any future war.

Any plan devised for the rotation of officers and enlisted men requires a cushion to enable its performance. This cushion results in wastage of medical manpower and is open to criticism. The full use of medical transport facilities for the transference of medical replacements rather than their restriction to general replacement transport means would implement a better rotation program. This concept was not allowed in practice during World War II and hindered the plans of the Surgeon General of the Army.

RESTRICTED

RESTRICTED

Many individuals overseas were redeployed to the Zone of Interior against their wishes because they had attained the required credits. Future planning should include the exemption of this class of patriots from the general provisions of redeployment directives. Further, the realization that each man has a breaking point is imperative in the future planning for war. Many good doctors were sent home through medical channels because it was the only "out" in their particular cases. They had worn themselves out faithfully in the service and should have been replaced by the operation of a replacement system which accepts the fact that most humans cannot withstand the hardships of war beyond a reasonable determined period overseas.

(3) Between Theaters of Operation

Very few individuals were redeployed as such between the various theaters. In most cases it was the desire of the individual or the specific need for his service that determined the assignment. Because of these factors very little criticism ensued. As there was no policy established for this type of reassignment no change is indicated.

c. Redeployment of Medical Units

The capitulation of Germany in May 1945 thrust the direction of all of our resources towards the Japanese Empire in the Pacific. A general increase in our armed forces right in the Pacific was needed for the final blows leading to victory. Plans to effect the transference of our forces from Europe to the Pacific included their medical support and thereby set in motion one of the most confused patterns of discontent encountered during the war. Some units were selected to go to the Pacific via the United States. Others were needed so vitally that direct transference was indicated. Policies were established that permitted of volunteering for further combat service. These fine sentiments were habitually expressed for service in those units which were to pass through the United States and resulted in their full complement on redeployment. This left the direct transfer group of units filled with those who were forced to join by lack of sufficient overseas credit. The units chosen for redeployment had to be completely reorganized and soon lost all semblance of efficiency. This did little to improve the morale and esprit of these forgotten units. It was over this stage of redeployment that most of the criticism arose. First of all, the system used was not sound militarily. It failed to utilize the experience of unit efficiency so greatly developed in Europe. It failed to take into account that the care of the sick and wounded was more important than the length of time the unit of its individuals had served overseas. It was based on the reorganization of a unit by applying individual credit for service in points which many held open to inequity. There is considerable agreement that a credit system for service was just and that overseas service should double the credit for Zone of Interior Service. This system was not adopted until after V-J Day and it was indicated sooner in the process of redeployment. Another suggestion affecting the redeployment of units has been made. It favors the sending of Zone of Interior medical units to a Theater of Operations rather than direct redeployment of veteran units from one theater

RESTRICTED

RESTRICTED

to another. This scheme has its merits only to the extent that it might equalize service. It presupposes the availability of similar combat medical units in the Zone of Interior ready for movement. Hindsight observations, however, based on World War II experience in this field should not be adopted in planning for the future, as the system proposed would entail great wastage of medical manpower held in training for possibilities that might never be realized. This would invoke more criticism by the very people who are now so adamant in criticising wastage of medical resources.

Another suggestion which has merit concerns the redeployment of units with only key personnel. This appears at first glance as an admirable proposal even though it may put the load for long overseas service on a few selected individuals. However, it does not assure the prime essential that any combat medical unit must be ready to operate immediately on its arrival in any theater of operations. For this reason it must be rejected as impractical in planning for the future. (Non-concurrence Air Force Medical).

Lack of desired amount of transportation was an influencing factor in implementing the systems used for redeployment. To assume that in the future we will have sufficient transportation for the ideal operation of our scheme of redeployment is unsound in light of our experience in past wars.

II. DEMOBILIZATION

The results of the mass hysteria of the nation following V-J Day demanding the immediate release of all non-regular personnel from the services is too well known to need much amplification in this report. However, the unsound actions of a nation which permitted total destruction of its armed might even in the knowledge that to do so was to destroy its most important facility and the opportunity for security of its prime aims, that of preventing future war, must be given due weight in planning for what might happen in the future under similar circumstances. It must remain exceedingly doubtful if any future Chief Executive can control the overwhelming demands of a people under our form of Government even if fortified with legal provisions which anticipate these demands.

It points out the need for the indoctrination of the American people by whatever means is necessary to again avoid the pitfalls of unpreparedness. It seems logical to accept the experience of World War II as the basis for planning for the demobilization of our forces in any future war, except for the rather universal opinion that any future war may bring to our homeland the destruction and chaos which both our Allies and our enemies experienced in World War II. If such occurs it will certainly affect the psychology and actions of our people far different from our latest experience. This may in the establishment and operation of an orderly and well planned process of demobilization whereby the armed services can adjust their resources in conformity with national needs and commitments. Regardless of the doubtfulness of conditions which will exist after the next war, a sound, gradual and well controlled demobilization process must be planned.

RESTRICTED

RESTRICTED

There is well founded knowledge in the services of the type of medical care which is demanded by the American people for its disabled war heroes while in governmental hands. There should be no system of demobilization of service medical personnel devised which will in any way affect the high standards of care, in spite of objection to post-war service by individual medical officers, that have been provided the disabled of World War I and II in our service facilities.

It has been suggested that demobilization of all forces be accomplished by units rather than as individuals. This would conserve personnel while avoiding rapid disintegration of strength. It would not be an equitable process, however, as no unit retains its original personnel throughout its life. Because of this feature it is hard to accept the suggestion as one which would still the critics of armed services methods.

The peculiar position which the medical services alone of all services occupy after war wherein they are required to retain a large portion of their personnel strength to care for the human carnage resulting from war should be more generally recognized by the civilian population as well as by high level service staff and command agencies.

Further indoctrination of the civilian medical fraternity as to their responsibility in this phase of national effort is indicated and cannot be too forcefully emphasized. It is not within the reasonable horizon of tomorrow to assume that the Veterans Bureau will have sufficient available beds for the rapid reduction of service medical loads immediately on the termination of hostilities. This process of relieving the service facility patient loads after hostilities has received universal acceptance as a sound procedure and should continue in the future.

Another important medical phase in demobilization involves the final physical examination of the troops prior to their release from service. In the light of present laws and regulations concerning claims for disabilities incurred as a result of service, it is imperative that adequate final type physical examinations be conducted. This onerous duty requires the retention of large numbers of medical officers in the service for long periods of time. There is much debate as to the value of these examinations as usually conducted at discharge centers. Blanket time limitations set by high authority for completion of all processes involved in discharge from the service have undeniably played an important part in the thoroughness of these examinations. Many hold they were worthless as conducted in the past and that it would be better to eliminate them completely and thus speed up the release of medical officers. There can be no justification for that attitude in the face of the legal responsibilities of the Government to claims by its former wartime personnel for emoluments connected with service and non-service connected disabilities.

There appears to be one solution only to this problem and that is the demand that sufficient time be allotted to the final physical examination phase of demobilization to permit of a thorough, complete physical survey of each individual from which reliable data

RESTRICTED

RESTRICTED

is established which will provide justice to the individual and protection to the Government for all claims resulting from the disabilities of war.

The need for medical officers in the specialties for post-war service in the rehabilitation of our wounded is definitely established and must be accepted by the medical profession regardless of their attitudes and desires.

Regardless of any system possible of operation in demobilization there will be inequities in priority of release of medical personnel forced by the magnitude of details involved. The system of publishing general blanket regulations and instructions for the demobilization of all officers cannot be accepted by the service medical departments as applicable to medical personnel. To enable them to discharge their responsibilities there must be special control by themselves over their personnel and resources. This must be realized by supreme authority.

The question of who should get out first can never be decided in the case of medical officers upon the individual desires of that officer although there are many justifiable reasons in each case. Uniformity of service rendered should have an important bearing as an index to separation in any demobilization process. The important consideration of foreign duty service wherein the individual has been subject to separation from family and comfort as well as to the hazards of war must be closely studied in determining the index for separation. A mathematical scale giving weights to Zone of Interior and foreign service seems most feasible for future use. Age of the individual should be considered because of its influence on the length of his possible future civilian pursuits and provision of financial security.

The enormity of the details involved in the proper phasing out of surplus medical personnel during demobilization while keeping the medical facilities balanced with qualified personnel precludes complete justice in each case under any system which can be devised. The movement of thousands of medical officers from place to place to carry out a detailed postwar replacement system based on absolute equity of each individual for service is not practical and therefore must be discarded as a means which might avoid disaffection. Because of "area" control over the medical personnel in Zone of Interior station and regional hospitals the Surgeon General of the Army was impotent to apply any equalization process affecting medical demobilization in those units. This was corrected in the final stages of the war to prevent many of the more glaring inequities which had occurred. Care should be used in delineating the responsibilities of Area Commanders in the future to exclude this aspect of the control of medical personnel. There can be no decentralization in policy-making if equality of service is to be the basis for medical manpower management in future wars.

Prior planning for the system to be used in the release of medical personnel must be accomplished in war and kept as flexible as possible to coincide with conditions as they actually exist on the term-

RESTRICTED

RESTRICTED

ination of war. It is doubtful if much improvement can be made in the demobilization processes of World War II unless a firmer national policy is established and adhered to consonant with our post-war military requirements and which will permit of a gradual, orderly phasing out of service personnel. The armed forces alone should be empowered to set the indices for separation and the methods by which separation will be accomplished. They should never again be stampeded by sentiment.

The Army, Navy and Air Force all have different needs during demobilization. There was a lack of uniformity in criteria for release between the Army and Navy. There should be coordinated action by all to the end that all medical personnel share equal service even if it occasionally may necessitate inter-service transfer.

Finally, full recognition of the Medical Department individual accomplishments for relief of innumerable cases of real hardship plus community and educational critical medical shortages has not been received. Such individuals returned to civilian life without expression of their appreciation by spirited public defense of the sincerity and conscientiousness of effort exerted by Military Medical authority, for their welfare, in spite of all the difficulties and problems for Medical coverage as remained in the services.

III. CONCLUSIONS

The Committee concludes:

1. That the next war may well pose features concerning redeployment and demobilization far different from past experience. That only until the actual conditions are assessed should definite plans be placed in operation but once initiated, consistency insofar as is humanly possible, should be the guiding principle. That pending another war there should be "desk drawer" plans made by each of the services which will serve as policy indicators to avoid past errors when the time arrives for redeployment or demobilization.

2. That most redeployment programs and policies as established and attempted in World War II were sound. That they were based on equality of service in principle which is predominantly accepted by all as fair and just.

3. Policies for Medical Department personnel management concerning rotation and redeployment must be made at the earliest possible date in event of war.

That because of the special nature of the Medical Department's mission exception to blanket personnel regulations and policies are indicated.

4. That full use of medical transport facilities, had it been permitted during the war, would have allowed a better rotation policy for medical personnel between the Zone of Interior and Theaters of Operation.

RESTRICTED

RESTRICTED

5. That a point credit system indicating service is essentially fair and just, and should be established at the outbreak of hostilities and maintained without discrimination for the rotation of each individual. That overseas and other service at isolated stations should be given more credit than Zone of Interior service. That the next war may well prove that home service is just as hazardous as overseas service. That this factor will demand consideration when and if war comes. That for separation of Medical Department personnel the post-war needs of the service must be evaluated and not permitted solely on any point system alone.

6. That a general rotation policy during war permitting rotation between a civilian and service status would impose a terrific burden and incidentally cause a wastage of practitioners. That it would set up a discriminatory practice unbearable to the American sense of justice and thereby prove a boomerang to the generally admitted sacrifice by the medical profession in war. That the next war may prove to be more hazardous in the XI and thus cause a reversal in this concept. That only in the rare exceptions of highly trained specialists should this suggestion receive consideration.

7. That rotation of specialists between Zone of Interior and Theater of Operations is indicated in the future on a wide scale to permit of more complete knowledge in the practice of their specialties. That this can be accomplished readily and soundly by definite planning and execution.

8. That those who volunteer to continue on overseas assignments be permitted to do so if able and qualified. That specific provisions should be made in blanket regulations governing rotation of officers and enlisted categories to exempt this group of personnel.

9. That rotation policies and procedures must envision the need for replacement of worn-out personnel as well as those with sufficient credits.

10. That the most economical method of redeployment of medical units between Theaters of Operation is one in which the entire unit is transferred regardless of the length of overseas service of its individual members. That this method, unless adopted for all other service units, would not prove popular and be unjust. That it is useless at this time to determine a policy in this field because of its dependence on specific situations, no two of which in past wars have been similar.

11. That the hysteria of the populace which resulted in the complete disintegration of our armed forces following V-J Day may recur, but is improbable in the event of atomic or other type warfare occurring in the continental United States. That to prevent foolish demands it will be necessary to indoctrinate the public during hostilities and to put teeth into legislation at that time which will permit the military to alone decide when each individual will be separated from the service.

12. That the peculiar missions of the Medical Departments in discharging their post-war responsibilities must be recognized to the end that the Surgeon Generals be given the autonomous right to decide when each medical individual shall be separated from his particular service.

RESTRICTED

RESTRICTED

That in no other way can the backlog in the care of battle casualties be concluded on the high plane of service demanded by the public and the final type of physical examination of individuals conducted on a worthwhile and just basis of all concerned.

13. That unless general policies for demobilization of personnel include enough time for a complete and searching final type physical examination of each individual the same worthless practices of World War I and II will ensue to the detriment of the taxpayer and individual alike.

14. That equitable wartime service between medical components of the Army, Navy and Air Force is desirable, sound, and should be practiced.

That it can be attained by joint coordination of effort even if it requires the interservice transfer of individuals to accomplish it.

IV. RECOMMENDATIONS

The Committee recommends:

1. That in future war planning be completed early for the rotation, redeployment and demobilization of medical personnel.

2. That steps to gain the necessary authority to more forcefully utilize higher priority Air and available medical transport facilities in war for the movement of medical personnel be taken NOW.

3. That the point credit system used in World War II for service be further developed and retained, for the rotation of general medical service personnel from theaters of operation to Zone of Interior, but that it not be adopted without modification for specialist categories depending upon their replacement availabilities.

4. That rotation between civilian and service status during war be not considered as practical except in the case of scarce category specialists.

5. That provisions be made in planning in event of war for the widespread rotation of specialist categories between the Zone of Interior and Theaters of Operation.

6. That every effort be made through medical sources to educate the public and its representatives of the folly of demobilizing the armed forces and its medical services in a similar fashion that occurred in World War II.

7. That necessary steps be taken at once to insure the following:

(1) Giving the Surgeon Generals of the Armed Forces the

RESTRICTED

RESTRICTED

authority to determine the criteria for discharge of medical personnel based upon their post-war medical service requirements.

(2) Sufficient time be allotted in the demobilization discharge process for a proper type final physical examination.

(3) Coordinated action by the Army, Navy and Air Forces equalize wartime service of their medical personnel.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Arthur B. Welsh, MC, USA
dated 19 April 1948)

***** "e. One criticism of redeployment was the failure to send doctors with no overseas experience to the Pacific from the zone of interior, rather than directly redeploying ones from the ETO. Demobilization was too fast. The post V-J day imposition of medical corps officer ceilings on overseas theaters--rather than permitting theaters to exist on lush T/O bodies, without a justifying workload, certainly accelerated the return of doctors to the zone of interior. The ETO on request returned large numbers of doctors to the zone of interior to assist in the evacuee work load imposed on some of interior hospitals. High command is to be complimented for approving that request. It shows what could be done even within the existing command structure. Maybe the reason the Medical Department didn't do so many desirable things is because of not knowing what it wanted to do or what should be done or how to staff the request. It's interesting to know that the Personnel Division of the SGO had splendid records on the global distribution of all army doctors. The greatest weakness was in determining the correctness of classification and requirements. There was too great a tendency to staff for peak loads. Manning tables were too lush and some of interior fixed hospitalization, particularly of the station and regional type, too ample. When The Surgeon General really got hold of the reins, some of interior installations closed rapidly and the demobilization of doctors was accelerated.

"A frequent criticism, perhaps unjust, was the Medical Department's failure to plan and obtain responsibility for the hospitalization of the veterans, which it is argued would have done more for the residency and professional training program of the Army and its future readiness for war than any other single move. Too, it would have reduced overhead and kept out or at least subdued another 'bidder' for doctors and ancillary service personnel.

"Redeployment and demobilization by unit was indicated. Such a plan had it been approved would have retained wartime unit esprit developed by having done a good job as a team. That wasn't War Department policy." *****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

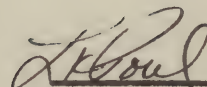
TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

**** "e. Redeployment and demobilization of personnel. A system of credits for demobilization should be established, and medical personnel demobilized when sufficient credits have been accumulated. It should be mandatory that personnel demobilized during the emergency return to their community and engage in their profession there; other personnel being selected from their community as replacements." ****

TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee dated 18 April 1948)

***** "(e) Redeployment and demobilization of personnel.

"There should be an orderly numerical priority system which would make demobilization automatic and fair. Medical men should not be retained longer than really needed."*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel F. A. Blesse, MC, USA, dated 19 April 1948)

*******5. Redeployment and demobilization of personnel.**

"a. Redeployment and demobilization of personnel is naturally expected to vary between the Army and the Navy because of the wide variations in the types of missions of the respective services. In the recent war the Navy policy of rotating overseas shore based personnel between duty at sea and the Zone of the Interior was far different than the Army's policy of indefinite overseas duty. This can well be understood when one considers the differences in missions. The correction of differences in redeployment policies will be difficult for it presents many problems. The difference in the rate of demobilization creates separate requirements for the number of Medical Department personnel to be retained on duty. This difference in rate of demobilization naturally resulted in variations in the separation criteria for Medical Department personnel as well as all other types of personnel. The only foreseeable solution to the problem of equalizing the demobilization of Medical Department personnel would be a system of inter-service transfer of such personnel.

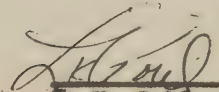
"b. It is likely that demobilization by units will follow the next war. Although this may be unfair to some individuals, it would tend to prevent the complete and rapid disintegration of the Armed Forces that followed World War II. It is believed that this system would conserve medical personnel, by enabling them to return to their civilian pursuits at the exact time they are no longer needed in the Army, rather than remain in the service until they accumulate enough "points" for discharge. This also promotes unit pride and improves morale.

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus (MC) USN
dated 27 April 1948)

***** "(e) The redeployment and demobilization of personnel should be carried out in an orderly manner and no more rapidly than is consistent with finishing the job of making war and cleaning up after the shooting stops." *****

RESTRICTED

295


E. K. Pohl, Colonel, MC

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

***** (E) 2. The average American is a pretty practical individual. If somebody can get across to him that the work he is doing is important and that he is needed, he can remain fairly well contented on the job. If he is stuck with a job and sees somebody of comparable ability going home, he wants some kind of a reason for it unless it's just a question of a law of averages. If you can explain it to him on that basis as a gamble, he will take it in pretty good spirits. If he feels he is being picked on, he won't like it, and during the demobilization period people are all anxious to get home, and those who can't get home immediately should have the situation explained to them in some way they can realize that they are contributing to the over-all effort.

"In answer to 4(E). The poor results in the final type physical examinations are now, I think, generally accepted. I feel that the medical department should protest, as it did, pressure from higher headquarters in turn was under such terrible pressure from the governmental agencies that after all all we can do is make our recommendations and act on orders. I think that the entire country made a horrible mistake, but I think the medical department did the best it could under the circumstances.

"I am not familiar with No. 6. I don't know what planning was done. I know that we all gave it considerable thought, but the big planning topside controlled what became of our plans; our plans could never really operate because of the over-all Washington level planning.

"In answer to No. 7, I suppose it did. I suppose there was overproduction, overprotection, and overcaution, but it's probably better that way than another way. It's much better to be too cautious in dealing with people's health than not being sufficiently cautious and then being caught.*****

"(I) 16. I favor a reasonable rotation policy for everybody. To answer the question specifically for specialists between the ZI and theater of operations, I would say yes, and for other classes I think within the limits of transportation and providing always that it's done equitably. They don't have some gang rotated 18 months and somebody else on a year and somebody else out four years and no change of coming home. Any rotation at all--this is my specific answer to this--must be on an equitable, even basis, because they are all Americans. It doesn't matter what kind of uniform they wear or what their rank is."*****

RECORDED

L. K. Pohl
L. K. Pohl, Colonel, MC

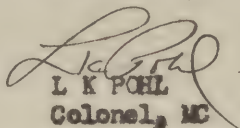
RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr MG Stayer, Major General, US Army, Retired, 19 Apr 48)

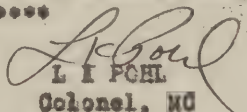
***** (e) Redeployment and demobilization of personnel.

It was tragic the way it was handled in this late war, but under the conditions, I believe the methods were as good as could be expected." *****


L. K. POHL
Colonel, MC

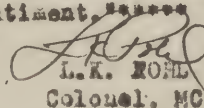
TRUE EXTRACT COPY (Ltr Brig. Gen. Guy B. Denit, MC, Surgeon, 13 Apr 1948)

***** "Redeployment and demobilization of personnel - This subject is so closely related to the mobilization that it should be studied and considered by the same Resources Board in order that a proper flow of Medical Department personnel may be directed back into civilian channels without hampering the military service during the period of adjustment."*****


L. K. POHL
Colonel, MC

TRUE EXTRACT COPY (Ltr Col. Robert P. Williams, MC, dated 16 April 1948)

***** "Redeployment and demobilization of personnel. Redeployment can be handled by first sending those who have served only in the Zone of Interior, to be followed by those with the least overseas service. Combat Zone Service should be given twice as much credit as other overseas. On the basis of universal draft, demobilization of medical personnel should be based on both military and civilian requirements. Complete plans for demobilization should be drawn during a war. The Armed Forces, if prepared, need not be stampeded by sentiment."*****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

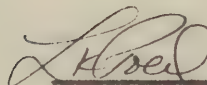
TRUE COPY EXTRACT (Letter, Colonel James H. Forsee, MC, USA, dated 20 April 1948)

***** "(E) Redeployment and Demobilization of Personnel.

Redeployment which followed World War II has demonstrated to most everyone that such a policy was most unwise. It would seem that all personnel overseas at the close of the War should be required to stay overseas until they have completed a prescribed period of service. Those who have met these requirements should be returned home and be replaced by those from the Zone of the Interior. A large force seems to be a pre-requisite for peace and to keep this number intact replacements coming from the Zone of the Interior would permit the discharge or separation from the service by those who have completed the prescribed period of duty. Duty in the Zone of the Interior in the absence of actual battle conditions might, as a suggestion, be given credit for overseas service on the basis of 80%, that is 2 months in the Zone of the Interior would equal 1 month of overseas duty."*****

TRUE COPY EXTRACT (Letter, Col. John A. Rogers, MC, USA (Ret.) dated 19 April 1948)

***** "E. Redeployment and demobilization of personnel. Headquarters of the First Army were redeployed to the Pacific Area immediately following V.E. It was my understanding at that time that many well trained and experienced medical units could not be redeployed to the Pacific because of a certain amount of service in the European Theater. It would seem that during a war the more experienced and better trained units should be more fully utilized regardless of length of service since failure to do so must inevitably result in a poorer standard of medical care for the wounded in a new theater. Efficient care of the wounded is a more serious consideration than the length of time the unit may have spent in combat. Demobilization should generally occur on a length of service basis at the conclusion of hostilities except in the case of key specialists in general hospitals in the Zone of the Interior." *****




L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr James E. Hix, Lt. Col., MC, (Resigned) 11 April 1948)

*****"The point system of last war didn't seem bad to me. Where transportation facilities permit, a more active rotation in and out of the combat zones might help."*****


L. K. POHL
Colonel MC

TRUE COPY EXTRACT (Letter, Brig. Gen. Robert C. McDonald, MC, USA (Ret.)
dated 15 April 1948)

***** "(e) Redeployment and demobilization of personnel.

"(1) Comment: Demobilization of specially qualified medical personnel was too rapid in the last war. Efforts to balance demobilization so as to retain sufficient specialists to maintain proper medical care and treatment were only partially successful. Redeployment was satisfactorily handled.

"(2) Suggestions: Redeployment and demobilization should be on a balanced plan so that overages and shortages of skilled personnel will be avoided. There must be a lag in the demobilization of medical personnel since the sick and wounded must be cared for until maximum improvement is attained."*****



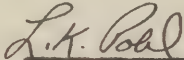
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Robert M. Gillett (MC) USN
dated 15 April 1948)

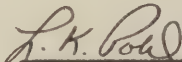
***** "Of all schemes of mobilization and demobilization of
medical personnel, the system used by Canada appeared to have the
most merit." *****



L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Dr. A. R. Shands, Jr. dated 20 April 1948)

***** " The redeployment and demobilization of personnel on the
whole was quite smoothly performed." *****



L. K. Pohl, Colonel, MC


RESTRICTED

RESTRICTED

TRUE EXTRACT-COPY:

(Letter from Colonel Richard T. Arnest, Ret.
dated 19 April 48)

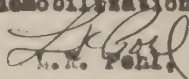
***** "e. Redeployment should be made with key personnel
only - the fillers would be added to the new theaters. Demobiliza-
tion should be accomplished purely on a length of service basis.//***



L. K. Pohl
Colonel, U. S. Army

TRUE COPY EXTRACT: (Ltr Rear Adm F.L. Conklin (MC) USN, dtd 37 Apr 48)

***** E. "Following the last war, demobilization was much too rapid,
as I believe everyone can see."*****


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Bascom L. Wilson, Colonel, MG, Air Force, 21 April 1948)

****Reference par 3(e) "Redeployment and demobilization of personnel," I can only speak of demobilization of personnel. During the rapid demobilization of personnel following the recent hostilities, apparently no prior thought had been given to the retaining of sufficient Medical Department personnel as well as other necessary administrative personnel, to effect an orderly and continuous demobilization without undue hardship and confusion, as was very apparent in demobilization as accomplished. As it was, key personnel in the various Separation Centers were constantly being shifted from place to place, and had to be replaced by untrained personnel due to vacancies constantly being created by release of such personnel. This, of course, created confusion and discontent in all concerned. Frequently, personnel due to be demobilized, were received at Separation Centers in such numbers that it was impossible to care for them, resulting in the necessity of putting large numbers on Leave awaiting their turn. Much difficulty and confusion in personnel accounting resulted. Medical and Dental officers, in particular, should have been key-noted in sufficient numbers and specialties for Separation Centers and retained in the Service until demobilization had reached such a point they could have been released. This would have resulted in a much more orderly and efficient procedure, and would have been in the interest of the individuals examined and carded as well as in the interest of the Government. Individual records would have been more complete and of greater value to the Veterans Administration for future reference."****

REK
L. K. POHL
Colonel, MG

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M. J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

***** (c) Redeployment and demobilization of personnel.

Here is a category and field concerning which must have been said and written. The serious burden and responsibilities that attended a rapid redeployment and demobilization were shared by our medical corps. The war being over, it was quite understandable that many of those who came from civilian life leaving behind them established practices and homes were most anxious to return as soon as possible. Many of the members of our profession made notable sacrifices, yet all were honored and privileged by the opportunity to serve their country. The sacrifice of our thousands of American dead must always be remembered.

It was not always possible to redeploy the medical officer in a situation which most adequately met his personal desires yet in many instances this was done and I think a good job in the main was done by our people. Demobilization activities were intense, and this haste resulted in certain disadvantages and difficulties. However, the rate of demobilization was determined largely by the wishes of our people. I think this process was well conducted despite the harsh criticism of some politicians and other interested parties." *****

RECEIVED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extracts from Ltr Col. Harry G. Armstrong, MC, 16 April 1948)

**** "a. Redeployment and Demobilization of Personnel

(1) Defects:

- (a) Lack of uniformity in program between various services and line branches.
- (b) Retention of personnel who had done a good job as essential.
- (c) Failure to establish definite policies relative to duty at undesirable stations.

(2) Remedies:

- (a) Operation of redeployment bases on plans used by other services.
- (b) Giving weight to age in demobilization plans.
- (c) Establish procedure relative to continental and overseas service for all personnel and stick to it."

RE

L. K. Pohl
L. K. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr Alfred W. Eyer, Captain (MC), USN, 17 April 1948)

****(c) Redeployment and demobilization of personnel.

"With the experiences of the past war freshly impressed upon the medical service consciousness, every effort should be made on Bureau levels to plan against a recurrence of the confusion and disorganization attendant at that time.

"Planning should include:-

"Indoctrination of potential inductees regarding the responsibilities and probable employment required during initial mobilization.

"A full understanding based upon enunciation of Departmental and Bureau policies that demobilization of medical personnel will be affected in graduated stages and occur during and subsequent to general service personnel demobilization. In other words, do not lock the door (medical processing and record preparation) when the barn is on fire and expect to get equipment and animals out in a reasonably efficient and accurate manner.

"It is realized that the impact of public demands can make an impossible situation. However, it is believed that indoctrination of the public through well controlled propaganda sources during a war can diminish greatly the urgency of such demands." ****

RECORDED
L. K. POHL
Colonel, MC

RESTRICTED

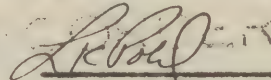
RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT
HISTORICAL RECORDS OF WORLD WAR II. (Ltr. 31 July 1943 fr Col. W. C. Grow
Surgeon 8th AF, to Brig. Gen. Grant TAS)

***** "A plan which might be put into effect to give the deserving officers a chance to get ahead would be to have some rotation policy worked out whereby outstanding group surgeons and squadron surgeons could be returned to the Zone of the Interior to head a wing or another group. It appears that these men with six to twelve months foreign service under their belt would make good officers to organize another outfit destined for this or another theater."*****

(51 Av. Sq. - MTO: Personnel)

***** "At present the biggest factor in any such problem has been the lack of promised rotation. The squadron has been overseas twenty-six months. Over ten months ago two men a month were selected for rotation and with the submission of their names they became frozen in grade. Occasionally orders would come in for rotation of men but with no sequence of transmittal whatsoever. Subsequently the men became somewhat skeptical and comparing the advantages of having their names sent in for rotation or refusing it and not being frozen for promotion, chose the latter. The plan to afford key personnel a thirty-day furlough in the United States was well received by the men but after three months have elapsed and we have returned no men, the personnel have become doubtful." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - APTAS.

***** E. "The ratio for the Air Force at that time was 1 dental officer to 1,300 men with the expectation that it would grow increasingly worse because the T/O did not provide for a sufficient number of dentists. It was estimated that a total of 176 dentists over and above those allowed on the existing T/O would be required to bring the ratio up to 1 to 850. The dental situation was probably causing the Medical Department "more concern" than any other problem during midsummer 1943. The duties imposed upon the dental officers in the UK were observed to be "particularly" heavy in October of that year. None of the 98 dental officers and 98 dental assistants who, according to WD Flow Chart for AAF, ETO, dated 8 November 1943, were scheduled to be shipped to the UK by January 1944 had arrived by 20 December 1943. A study based upon provisions of the War Department Flow Chart revealed there was a shortage of 207 dental officers and 187 dental enlisted men in the Eighth and Ninth Air Forces in February 1944.

Rotation of Medical Officer Personnel. Disappointment over rank and promotions was not the only cause of the lamentable state of morale among Air Force medical officers. They were conscious of the obvious discrimination practiced against them in the matter of rotation to the Zone of Interior. The conditions under which the surgeons worked, "including particularly the inability to do much real medical study and practice," produced states of discouragement, depression and frustration that led to "understandable attitudes of indifference and some loss of efficiency.". After twenty-four to thirty months overseas medical and dental officers would invariably get in a rut, lose interest, and suffer a decline in efficiency.

Escape through rotation to the Zone of Interior was a universal aspiration of medical officers in 1944. It was so strong and widespread that the First Bombardment Division requested "That authoritative information on the planning for rotation and professional opportunities be disseminated more fluidly to the medical personnel in order to effect any unfounded rumors. In March it was suggested to the Air Surgeon that channels should be provided whereby surgeons, particularly those in the Tactical units and the Central Medical Establishment, could be easily rotated when such a course was deemed useful. At this time there were many medical officers in the states anxious to fill the places of those who had served many months overseas. An exchange, it was said, would be to the best interest of the flight surgeons and improve the care of the flier. Two months later, he commented on the "marked degree" of difficulty which had developed over the question of rotation of Medical Department officers. He said there had been no "legalized rotation" in the theater since its inception. Medical officers could only be sent back to the states for training at the School of Aviation Medicine, on account of illness through the hospital or by what might be termed "sight of hand." On the other hand, combat aircrew personnel due to losses and completion of tours of duty had changed four or five times at some stations during approximately three years of war. Length of service overseas, not the shortage or availability of medical personnel was, it appears the principal factor in determining the policy of rotation or deployment at the cessation of hostilities in Europe.*****

RESTRICTED

RECORDED

L. E. POHL, Colonel, MC

RESTRICTED

Extract (Statements made by Brig Gen Robert C. McDonald, MC USA (Retired),
21 April 1948, before the Subcommittee on the Employment of Military Medical
Resources.

***"Redeployment and demobilization of personnel."

"Demobilization of specially qualified medical personnel was too rapid in the last war. Efforts to balance demobilization so as to retain sufficient specialists to maintain proper medical care and treatment were only partially successful"

So far as I know, redeployment was fairly satisfactorily handled. I know that my consultants disappeared pretty rapidly after the defeat of the Japs, and we really needed them to take care of the large number of wounded and special cases that we had in our twelve general hospitals. We needed them for at least an additional six months.

"Redeployment and demobilization should be on a balanced plan so that overages and shortages of skilled personnel will be avoided. There must be a lag in the demobilization of medical personnel since the sick and wounded must be cared for until maximum improvement is attained."

A great many of our medical specialists were in a hurry to get back to their work in civil life. We can't blame them for that, but they left us pretty high and dry as far as that consultation service went in many instances.

Regarding the subject "Medical Department Organizations from the standpoint of personnel, equipment, training, and mission or tactical employment."

"How can we prevent physical examining boards from becoming disgruntled during the demobilization period?"

I don't think it can be avoided entirely. I think careful consideration should be given of personnel that would be assigned to these Boards. Those who are more worthy should be released. But keep on duty those whom we have to have. There is no solution to that.

"Should the speed demanded by higher staff in a demobilization be accepted by the medical department with its consequent poor results in the final type physical examinations? Should we insist on more time and a more thorough physical examination to prevent unjust claims?"

There should be time enough for thorough physical examinations. It would save the Government money and would prevent some unjust claims. There would still be plenty of them.***

RECORDED
L. A. FdL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Extracts of statements made by Colonel Thomas J. Hartford, MC, USA on 23 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

***** "e. "Redeployment and demobilization of personnel," my ideas are so old-fashioned on that, I am afraid they wouldn't fit in. I still believe there would have been less howl and better feeling by everyone if they would have been demobilized by units. In other words, if I could have told the 35th evacuation hospital, "Sorry to have to pick on you boys, but you have been a good outfit. I am not going to be able to send any of you home regardless of how long you have been over here, until the 15th of March, " I would have had a lot less howl that I did with 6,000 patients in beds and getting doctors in and out so fast we didn't know whether they had been sent to us for duty or whether we were supposed to have put them to bed. I don't think that's going to change the situation, but it's what I think. *****

RECORDER

L. K. Pohl

L. K. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain W. D. Small, (MC), U. S. Navy
dated 5 May 1948)

***** "5. Redeployment and demobilization as managed in World War II left much room for improvement. It is my opinion that demobilization was conducted mainly by hysterical and political expediency without much consideration for the welfare of those requiring medical treatment and resulted in premature disorganization of major medical installations. It took us nearly two years to recover in our Naval Hospitals from the effects of this hasty demobilizations. To avoid a repetition will require

(a). A careful and effectual mass education of the citizenry.

(b). A firm stand by the Congress to resist pressure for too rapid demobilization. The Armed Forces alone cannot accomplish an orderly exodus of personnel without full backing from the highest authority.*****

REC

L. K. Pehl

L. K. Pehl, Colonel, MC

RESTRICTED

RESTRICTED

**TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE MEDITERRANEAN THEATER
HISTORICAL SECTION -AFTAS**

***** E. "The shortage of medical officers, which at times had created a serious problem, was entirely overcome by January 1945. Indeed at times there was a surplus, especially in the field grades - a situation occasioned primarily by reducing the rank of the surgeon from major to captain under new tables of organization for several units and by the influx of replacements in the field grades from the Zone of the Interior. Replacements of medical enlisted men continued to be meager; however, owing to the policy of distributing enlisted men among the unit medical sections on the basis of the minimum number for operational efficiency, little inconvenience was experienced.

A further deterrent to promotion of medical officers and enlisted men in the theater was the policy of making replacements in rank or grade both from the Zone of the Interior and within the theater. This practice, especially that of sending officer replacements in field grade to theater, was the subject of strong protest by the Surgeon, Fifteenth Air Force.*****

L.H. FORD
L.H. FORD, Colonel, MC

TRUE EXTRACT COPY (Ltr Brig. Gen. G.E. Kennebeck, Dental Corps, dtd 7 May 48)

***** E. "In order to spread the combat duties evenly, provisions should be made so that dental officers are returned to the zone of interior for duty after a reasonable amount of service in combat areas. They should be replaced by those who have not had combat duty. It is believed that one year of combat duty before rotation is reasonable."*****

L.H. FORD
L.H. FORD, Colonel, MC

RESTRICTED

RESTRICTED


TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANG, 27 Apr 48.

***** E. " The method of demobilization adversely affected the operation of our Corps. Rather than being allowed to demobilize according to the desires of the nurse officers which would have allowed those desiring to be separated to be separated from the service, with retention of those who wanted further Army service. We, of course, had to demobilize according to the point system as was set up for the entire Army; but I think that, had we been allowed to do it the other way, many of our problems that we are having to meet right now wouldn't exist. Many of our people were forced out because of the point system. Some of them have become settled in civilian positions, and they are not interested in coming back to us in an organization which is again going to force them out as our needs are decreased.

We felt, too, that the establishment of a counseling service at demobilization centers for women's professional groups might, in the future, be a forward step to maintaining good personnel relations because many of the nurses who did get out felt they were forced out, and then they felt there was nobody there to give them any assistance or advice in nursing matters. They had been out of the country for some time, and they felt they were away from the nursing situation.

BRIGADIER GENERAL MARTIN: Do you favor reasonable retention for nurses during war between theaters of operation and the zone of interior?

COLONEL PHILLIPS: I do if it can be arranged. I think it's a mistake to keep people overseas, particularly in isolated areas or where living and working conditions are difficult, too long a time, but I don't know what we would have done or how we could have arranged it during this last War with the transportation problem in the areas we had to cover. I think some of the complaints that we first received from people wanting retention could have been taken care of had we been able to orient all our people before as to what they could expect in the way of service and the needs of the service. It was interesting, after we did set up retention policies, that many of them that we thought wanted to get home so badly found out they weren't so anxious to leave.*****


L.E. FOEL, Colonel, MG

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REYDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** "(E) 1. I believe the lack of transportation was one of the key blocks in implementing the plans. Another factor was that a certain number had to remain in the theatre to take care of sick and wounded still there. Another had to stay for occupation troops. It was in the selection of the personnel that a lot of the trouble came. In FTO apparently the medical administrative officer had a lot to do with the selection. It didn't do the good name of the Medical Department any good.

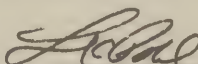
"2. I think one solution would be to assign a doctor to the Board for a limited period of time, say, 45 days or 60 at the most.

"3. I believe it was. I think the important part of it was the overseas service which meant separation from families, etc. The ones over longest should have come back first.

"4. I don't see where it makes any big difference because they can apply to the Veterans Administration anyway. Make it as fast as they want.

"5. From where I sat I couldn't tell. I felt the Surgeon General's office had its way pretty much.

"6. Answered above. Also, remember the clamor in Ground Forces Units. They were kept on a training status for quite a long time. I don't know how that can be avoided. Public opinion eliminated all those units."*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain H. D. Templeton, MC, USN
dated 23 April 1948)

***** "(E) REDEPLOYMENT AND DEMOBILIZATION OF PERSONNEL.

"The sudden cessation of hostilities was followed by a general lowering of the morale of all troops, especially those in the forward areas, and it does seem entirely feasible that a quick evaluation of the situation in light of the personnel required to garrison occupied areas should have been made. Those whose services were not urgently required should have been demobilized as quickly as possible. Much unrest and ill will was engendered when certain professionally qualified personnel were retained while others were separated. It is believed that the point system was quite effective, but the preference shown those who were not urgently required in the separation proceedings, caused much unrest among those who were retained for a longer period of time. Had the flow of separation been made slower, the burden of this duty could have been accomplished more expeditiously and more thoroughly." *****

RESTRICTED

L. K. Pohl
L. K. Pohl, Colonel, MC

314

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel O. F. McIlhenny, MC, Air Force
dated 20 April 1948)

***** "e. Redeployment and demobilization of professional personnel should be handled as expeditiously as possible in order to obviate unemployment of medical talent. Whenever it is discovered that there is an excess of professional personnel in any Theater of Operations or within the Zone of Interior and whenever redeployment of this personnel is not essential, such personnel should be returned to their civilian communities and the overall policy of demobilization should be 'first in, first out'. It might become necessary, should the military situation change, to recall this personnel, but it would be far better to permit them to return to a community in which their professional services were required than to waste their professional talent." *****

RECORDED

RESTRICTED

L. K. Pohl
L. K. Pohl, Colonel, MC

315

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C.B. Caneror (MC), U.S.N.,
Retired dated 21 April 1948)

****(e) By all means this should be accomplished GRADUALLY and ONLY when their services can be conveniently spared without undue hardship to the Service. This hysterical and recklessly hurried demobilization of Medical Personnel practically wrecked many activities, as is well and painfully recalled by all, and should NEVER be permitted to recur in the future. The greater amount of adverse criticism directed at Service Medical care stems from this pernicious practice, which is not only wholly uncalled for but readily avoided by merely retaining essential personnel UNTIL THEY CAN BE CONVENIENTLY SPARED BY THE SERVICES.*

L. K. Pohl

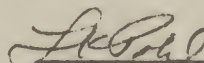
L. K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain C. D. Middlestadt, (MC) USN
dated 17 April 1948)

***** "Referring to paragraph 3(e), there is need of better cooperation in demobilization of personnel connected with Fleet Hospitals. At Fleet Hospital #114, there was no regard or consideration given by certain line officers to the needs of the sick and wounded. Personnel required for services such as electricians were withdrawn and had to be taken over by hospital corpsmen who had no training. As a result the electrical service and refers were out of order and the care of the sick and wounded imparalleled. The hospital finally had to close for the want of necessary repairs. This was chiefly the fault of a bullheaded line officer in charge of assigning enlisted ratings. This individual had no use for the medical corps." *****



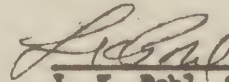
L. K. Pehl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. C. Greaves (MC) USN
dated 17 April 1948)

***** "(e) The high morale among U. S. Navy medical personnel in the Mediterranean Theatre of Operations was a source of satisfaction. It is believed that one of the principal reasons for this favorable attitude was the early establishment of a policy of deployment. Medical Department personnel coming into the Theatre for assignment were informed that they would be returned to the United States at the end of 18 months and the policy was carried out, except in individuals who requested extensions. It is believed that a similar policy of fixed tours of duty for all medical department personnel in any future war, provided of course that the exigencies of the situation will permit, will make the duty seem less arduous and will permit a certain amount of family planning which all normal individuals appreciate." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain O. B. Morrison, Jr., MC, USN
dated 23 April 1948)

***** "a. Redeployment and demobilization of personnel.

The planning phase which occurs between one combat mission and another is usually a period of inactivity for many of the medical personnel. After the strenuous days of combat, this period of forced inactivity and idleness is deadly for morale. Corps Surgeons should have authority to redeploy such personnel so that they could be assigned to fleet or base hospitals. This period is a busy time for these hospitals and they need extra help to care for the casualties, and the individual medical officer finds stimulating professional work under pleasant conditions.

Once the fighting is over, it is natural human trait to wish to return to one's loved ones and to the ease and comforts of civil pursuits. However, the rapid and hysterical type of demobilization which followed V-J day is a dangerous procedure, which can easily turn victory into defeat, and if not checked, is sure to lead to national suicide. " *****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

319

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert E. Simpson, USA (Ret.)
dated 1 May 1948)

**** "(e) Redeployment and demobilization of personnel. No comment other than apparently the "point" system appears to be satisfactory. More effort, probably, should be exerted to persuade exceptionally capable young officers to consider permanent commission in the Armed Forces as a career." ****

RECORDED

[Signature]
L. E. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 22 April 1948)

cccc "(e) Redeployment and demobilization of personnel-- From a mental health standpoint we were confronted repeatedly with the fact that men from the MFO were brought back to America, presumably to be trained for the Pacific by men who had never had any experience in the Pacific and were regarded by the trainees as "giving orders out of a book." I never knew for sure whether this was true or not but we believed that it was an extremely important factor in the loss of manpower in redeployed troops."cccc

REC
L. E. Pohl

L. E. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT

(Letter, Captain Bennett A. Hightower (MC), U. S. Navy
dated 21 April 1948)

***** "(c) All excess medical personnel should be removed from combat and auxiliary vessels within a few weeks after cessation of hostilities and assigned to hospitals. In addition, an effort should be made to assign the above personnel to duties ashore between operations, where practicable." *****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL JONNELL, MC, USA, 30 April 1948

***** E. "Certain specialists suffered in this respect more than the general run of medical officers that were redeployed to another theater after two or three years overseas. There were doubtless others in the ZI with excellent general hospital training who could have been replaced by these men. Do not demobilize these home units and redeploy overseas units. Use the ZI units as replacements.

I know there are many rambling ideas on that, but you hear that brought up so often, and there are concrete examples and I shan't try to expand on it. That's just the general idea that many people have, I am sure.*****

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS, (MC) USN.
4 May 1948.

*****E. "The next item is redeployment and demobilization of personnel. A good deal of complaint was made by individual officers, particularly during the demobilization period. Do you have any comment about demobilization officers?

REAR ADMIRAL WILLCUTTS: I think we have seen nothing compared to what we are going to see next time. It is going to be total war. In the old days, in the Spanish-American War demobilization was easy. The war was over and we went back home. In World War I we had our problems. I well remember how everything and everybody was itked and itching to get back home. I came back from France hoping to go home right away. I couldn't for I was held up someplace, Quantico, for 60 to 90 days.

We must have an orderly demobilization program. In World War II we tried to get it. Coming to this next war, this total war, we will have mass destruction. We know we will. We just can't have a war without shooting these weapons off that are so efficient. True they said that you had chemical warfare and didn't employ it to any great extent. I don't believe we can be able to control this bomb to that extent, - maybe not the atomic bomb but these other bombs which they say are just as efficient, or almost so, as the atomic bomb. If we have these guided missiles you will definitely have mass destruction of towns and cities, just like they had in Japan.

As to demobilization, we will be all one American family, and the needs will be such that I definitely believe that it will answer itself. The problems will have to be solved at that time. There is nothing in war today that gives us a pattern as to what is going to come the next time. I think it is going to take open mindedness. The needs of Civil Defense as well as our Services will be balanced off at the moment.

It is just too terrible. I have gone Quaker. My dad was a Quaker, and I understand that.

REAR ADMIRAL ANDERSON: Are there any questions on this subject: (none)

F. L. K. Fohl
F. L. K. FOHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA,
13 May 1948)

MAJOR GENERAL KENNER: ***** "Going to redeployment and demobilization of personnel, it should be in consonance with that of the troops, with retention and rotation of key personnel accomplished by surplus declarations as requirements indicate.

In our last redeployment we suffered an almost complete disintegration of the medical services. The personal equation -- the personal desires were paramount, to the detriment of the obligation of the medical officer to the Army. We were hard put to maintain any semblance of a medical service. On the one hand the Reserve Officers were counting their points and wanting out; and on the other hand, in my theatre, the surgeon general was calling by name for the remaining Regular medical officers who were key men and all that I had to run the medical service with. And I believe, therefore, that the major requirement, which is military, should determine when any medical officer may be separated. That again places the authority for that within the province of the senior surgeon, which he accomplishes by stating that doctor so and so is surplus within this theatre. In that way he can keep his hands on a doctor.

We had units we deployed and every doctor going back, some of whom did not meet separation criteria. And they were held on duty in the ZI until they did meet the separation criteria. We were denied their services during that period. They got aboard boats due to administrative errors and complications, without the knowledge of the surgeon. And the surgeon would find that instead of having so many doctors 200 had gone without his knowledge.

BRIGADIER GENERAL MARTIN: Do you consider it feasible to write into plans for the future, in the event that the ASTP and V-12 programs are to be continued in future emergencies, a provision that a specified term of service will be required upon the completion of their internship?

MAJOR GENERAL KENNER: I believe that the ASTP Medical Officer has a distinct obligation to serve in the military services for a period not in excess of five years, as may be determined in conformity with military requirements. I believe, in view of the fact that he was exempted from the draft while his contemporaries were being drafted to be shot at, that he should be available for whatever assignment may be indicated."*****

L. K. Pohl

RESTRICTED

L. K. Pohl, Colonel, MC

RESTRICTED

D-1 f. Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirements.

I. DISCUSSION

1. Review of the comments on this subject received by the Sub-Committee indicate that in the over-all there is little basis for controversy regarding the effectiveness of Medical Department organizations in carrying out the mission of the medical services during World War II. The numerous medical units represented careful thinking, planning and execution. There were no fundamental or basic faults in the types of these organizations, in their personnel, equipment or training. Changes to adapt such organizations to demands of their operational activities progressed more efficiently and expeditiously as experience was gained during the progress of the war. There were, however, many instances which should come under constructive criticism and should be taken into account in current planning.

2. There has been much criticism that Medical Department organizations were often overstaffed with medical personnel during World War II. This criticism is based on the fact that many medical officers spent considerable periods of time in idleness and that medical officers were frequently employed in non-professional duties.

3. Many Medical Department organizations were assembled in the United States for long periods before they were actively employed. Many doctors were idle at staging points in the United States and overseas pending shipment of their organizations to areas of operation. These delays were caused by temporary postponement of or changes in contemplated operations. Medical units were often shipped overseas long in advance of the expected time of their employment. Because of the shipping shortage theater surgeons could not otherwise be assured that these units would arrive when needed. These difficulties could have been obviated, in part at least, by a more adequate liaison between the offices of the Chiefs of the Medical Departments and planning agencies of the War and Navy Departments.

4. Medical talent will again become a critical item in the event of another national emergency and should not be dissipated by requiring medical officers to perform numerous non-professional duties. A great saving in professional personnel could be accomplished by changes in Medical Department organizations aimed at permitting medical officers to devote practically their entire effort in the professional care of patients. Properly qualified senior medical officers must be employed in certain administrative positions such as commanding officers and executive officers of hospitals and other medical units and as members of command staffs. With these and certain other exceptions, medical officers should be relieved of all administrative responsibilities. These non-professional duties can be effectively performed by properly qualified medical service corps officers and other non-medical personnel. Freeing physicians and surgeons of these duties would permit them to assume responsibility for the care of many more patients and would result in a much more economical use of medical personnel resources.

5. In the event of another war the need for conserving dental

RESTRICTED

RESTRICTED

and nursing personnel will again become urgent. Their services should be restricted to professional work. Medical Service Corps officers and non-commissioned officers should be trained and employed in relieving dental officers of administrative and other non-professional duties. Members of the Women's Auxiliary Corps should be considered with a view to relieving graduate nurses of many duties they now perform. If given a short concentrated course in practical nursing, these women could accomplish much of the administrative work of the nursing service, and assist the nurses in their professional duties.

6. Greater flexibility in medical organizations would result in better medical care and a saving in professional personnel. In the past, medical personnel have been assigned to organizations where there was little professional work for them to do on the grounds that their services must be available in case of some type of catastrophe. Tables of organization should be studied with a view to adjustment of the number of medical officers on the basis of the professional work which the organization usually and routinely will be called upon to perform. Provision should be made for the expansion or reduction of medical units by the theater or area surgeon as the situation may demand. Medical Department personnel pools employed at hospitals within the theater or area should be available to the responsible surgeon for assignment to medical units where their services are needed. The more general employment of combat surgical and other specialty teams would contribute to better medical care with less wastage of professional personnel.

7. In the Navy many doctors were employed as medical officers of small ships where there was little professional work. These vessels lack facilities for the full utilization of a medical officer's talent. In general these ships operate in company with larger vessels where adequate medical facilities are available. The more general employment of hospital corpsmen qualified for independent duty under the supervision of a medical officer on the squadron flagship would release many medical officers for other assignments.

8. Field medical equipment supplied during World War II was in general well adapted for the purposes for which it was designed and served adequately in most organizations. However, there is ample room for improvement. Continued research and development are essential to correct deficiencies experienced in the field and to keep abreast with new materials and designs and with the contemplated tactical employment of troops. Responsibility for the study and development of medical equipment for land warfare should rest with Surgeon General's office; for naval and amphibious operations, with the Bureau of Medicine and Surgery; for Air Force operations, with the Air Surgeon's office. Arrangement for coordination of this effort should be made.

9. Field medical equipment is too heavy and should be redesigned in the light of modern air and motor transportation. Improved housing of a light type should be developed for medical units in the communication zone. Tentage is very little different from that employed during the Civil War. Heating and lighting facilities for medical units at advanced bases and in the field require further study and development. Special attention should be given to adapting medical equipment to atomic, bacteriological and Arctic warfare.

10. Provision should be made for the construction of suitable

RESTRICTED

RESTRICTED

buildings for Army hospitals sent overseas after the tent stage of the campaign is completed. These hospitals frequently functioned in tents without floors long after headquarters personnel were living in prefabricated buildings. Navy hospitals sent overseas were not designed to operate in tents and were unable to function during the several months required for the construction of buildings. These hospitals should all have tentage and be prepared to set up and operate immediately. Construction facilities for semi-permanent housing should be made available as early as possible for fixed hospitals in the communication zone. Buildings supplied medical units at advanced bases should conform in general type to those used throughout advanced base areas.

11. Hospital ships were not available in sufficient number during the early years of the war. There was one hospital ship only in the Pacific during the first thirteen months of the war. Troop transports necessarily employed for surface evacuation lacked adequate facilities for the care of casualties during amphibious operations. There was not sufficient room space for examinations and operations, for the care of officer patients, convalescent patients and other special types of cases. Three specially designed hospital transports served most satisfactorily in the Pacific. Additional hospital ships became available as the war progressed and by V-J day the number of such vessels was adequate.

12. Greater attention should be given to training in amphibious operations by the Army in conjunction with the Navy. Casualty handling on the beaches and seaward should be given further study. The medical sections of beach and shore parties in the Pacific were assembled from transports and from various units of the Marine Corps. It is essential that the shore party medical section be organized and trained as a unit. The use of the LST (Hospital) off-shore for the care of non-transportable wounded and as an agency for routing casualty laden boats to the transports proved the value of such a vessel in casualty evacuation.

13. Navy Organizations and Army and Air Force, as well, charged with the responsibility of preventive medicine in overseas areas were handicapped by the lack of sanitary companies under the control of the Medical Department. Malaria control and epidemiological units relied on sanitary sections of construction battalions to carry out recommended measures for the prevention of insect-borne disease. Higher priority for the employment of engineer personnel in the construction of bases, ports, air strips, roads, etc. led to failure to carry out measures which would have prevented thousands of sick days among the troops. The solution of this problem rests in the organization of sanitary companies under medical control whose primary function would be the work necessary for epidemic disease control.

14. Air Force organizations during World War II consisted essentially of the following: (a) Air Group and Squadron intrinsic Medical personnel and equipment. These were present in Headquarters, combat, service, and air depot groups. The strength adjustments between such units and frequent necessity for advance air echelon and rear surface echelon movements resulted in many varied requirements so that at times personnel and equipment were more than adequate and then later with complete group

RESTRICTED

RESTRICTED

dispersal by Squadron, the coverage available was scarcely sufficient. (b) Approximately and not less than 20-25% of all Air Force troops in any theater were present as small units without attached medical personnel and supposedly to be covered by other Air Force units or Ground Force units having Medical Department service. Such did not obtain constantly, and the problem was of such degree that the Air Force Aviation Medical Dispensaries were evolved of Reduced Strength and Full Strength types. Their extreme usefulness and service value were proven repeatedly and provision should be made to continue their existence in event of another emergency. (c) The Central Medical Establishment as developed for many Major Air Forces was an essential structure, the provision of which insured adequate handling of those problems peculiar to flying and including: Air-Sea Rescue, flying equipment indoctrination, physiological and psychological problems peculiar to flying, medical requirements of flying evaluation boards, studies of special aero-medical equipment and rest camp supervision from Medical aspects. The Central Medical Establishment in proportionate strength as required by the size of the Air Force Command should be considered a unit evolving from World War II which has been tested and proven invaluable. They should be provided for in future Air Force planning T/O's and E's. (d) The Field Hospital (Army) was most adaptable to the needs of Air Force hospitalization in the immediate vicinity of less permanent and somewhat concentrated Air Fields. In concentrated areas the Station Hospital (Army) both 250 and 500 bed, were successfully operated by Air Force Commands. The movement by air of personnel and equipment for 100 to 200 bed unit hospitals to cover large bomber bases in isolated areas from Army and Communication Zone operational activities was not infrequent. The development of equipment therefore so as to facilitate air movement should receive adequate planning, consideration and action. (e) The Medical Supply Platoon (Avn) was a most useful unit adaptable to Air Depot Group and Service Center operation for Air Force units on one hand and to independent area Air Force Medical supply distribution on the other. Inexperienced and ill-advised individuals observing such installations in the vicinity of main army or base section depots undoubtedly considered such activity and speak of it now as unnecessary duplication. Such was not the case! The main depot requisitioning, receiving, storing and forwarding medical supplies from the zone of the interior could in no way provide the medical supply distributing service required for dispersed and multiple Air Force units. The effective liaison in use of air transportation for critical medical supply items to Army, Navy and Air Force echelons was provided with consequent avoidance of loss of many medical supplies, prompt air shipment to proper unit destination and with almost complete discontinuation of earlier practices in which Air Force unit Surgeons in particular, had to and did utilize combat aircraft and critical gasoline to return to base depot areas for replenishment of exhausted critical medical supplies. Air Force medical supply platoons (aviation) were most adaptable to usage by expansion for main depot operation when Medical Supply Depot units (Army) were unavailable for that purpose. Full utilization of Medical Supply Platoons (Avn) by Air Force agencies was not allowed in all instances in World War II. Their retention and conversion for service to other troops as occurred in many instances is condemned and should not be countenanced without fulfillment of the Air Force Medical supply needs as concurred with by the Air Surgeon concerned, except in most serious emergency relative to Theater Medical Supply.

RESTRICTED

RESTRICTED

(f) Other Air Force Medical Department organizations which were utilized to fill particular needs were the portable surgical hospital for Air Forces; the Veterinary Platoon (Avn); Central Dental Unit and Dental Operating Detachment (Mobile); Medical Sections for Aircraft Repair Units Floating and Aircraft Maintenance Units Floating. Other Army units utilized successfully by the Air Forces in World War II under Air Force administration and operational control included the Malaria survey and control units and General Hospital (1000 bed unit).

15. It has been ascertained that Air Force Medical organizations are now undergoing careful scrutiny and proposed revision for anticipated future needs. It is believed the experiences occasioned by World War II will be invaluable for such determinations and the requirements deemed necessary should receive fullest support for authorization in view of the present international situation and the extreme likelihood that in the event of a sudden war, Air Force participation will be required initially prior to the possibility of movement or involvement of any significantly large bodies of troops or seagoing vessels other than aircraft carriers, submarines and major fleet battle units.

16. In view of the emphasis now being placed on the provision of Air transportability for Ground Force units, the redesigning of all equipment of combat medical units that will be necessary to support operations of that type is indicated.

17. The communications between medical field units and the Chief Surgeons Headquarters in large force was inadequate and faulty during World War II. It varied at times from standard wire system to the use of pigeons. Much confusion and needless effort resulted. The British medical units of comparable nature are equipped with radio systems of inter-communication. It is believed that the efficiency of all field Army medical installations would be immeasurably improved if our units were so equipped.

II. CONCLUSIONS

1. That Medical Department units require continual study and modification to meet current operational demands of troops for which they render combat support, and the experiences of World War II should be utilized fully to avoid future errors such as overstaffing, understaffing, inadequate training, and premature staging over long periods, with full complements prior to shipment.

2. That staffing of Medical Department units at all times should be such as to utilize only those professional personnel on professional duties to the greatest possible extent and as are absolutely required for the present or immediate mission or projected tactical requirement of such unit.

3. That much flexibility in personnel and equipment for all medical units is a must requirement and should be allowed and provided practically at all times when deemed necessary by Chief Force, Command and local Surgeons concerned.

RESTRICTED

RESTRICTED

4. That manning of Medical Department units must contemplate increased utilization of responsible and adequately trained MSC officers and enlisted personnel so that professional use at all times of doctors, dentists, nurses, etc., may be more attainable.

5. That redesign of units and organizational medical equipment should consider its adaptability for air lift. Further, that this be subjected to coordinated and joint effort.

6. That housing facilities, of a temporary nature for dispensaries and hospitals as were provided in World War II were unsuitable and should receive joint coordinated intensive study and revision of design, construction material and for the provision of adequate utilities and maintenance.

7. That new units developed during World War II and of proven great value, should be used as basic planning models for units and organizations now under study for utilization by the Army, Navy and Air Force and that the Force concerned should be allowed every possible opportunity and be extended all cooperative assistance for determination of specific needs of each of the three Armed Forces.

8. That Medical Department units subject to mutual or similar use by each Armed Force concerned, be organized, equipped and considered for standardisation in every possible feature.

9. That there is need for improving communications between large field medical units in war.

That the use of radio would solve many of the difficulties encountered in this field during past wars.

III. RECOMMENDATIONS

1. That each Armed Force planning agency for the Medical support thereof extended coordinated and joint effort to effect the following:

a. Designation of Medical units necessary for immediate support of their Combat and Service troops in the ZI and in Theaters of Operation.

b. Determination of units and organizations with their structure, which may be standardized and subjected to mutual interchangeable usage.

c. That Army, Navy and Air Force approval and necessary allotment for medical units and organizations peculiar to the needs thereof be insured during peace in preparation for war.

2. That necessary appropriations be procured to insure the development and earliest possible procurement in event of war of standard equipment for Medical Department use, most suitable for air lift. That

RESTRICTED

RESTRICTED

the agencies now involved in such work be provided most able and experienced personnel. That coordinated joint efforts in that direction be stimulated to the utmost by each of the Medical Departments. That the Air Force facilities, their previous experience and cooperation in effort should be utilized to the maximum by Medical representatives.

3. That tentage, construction features of Medical installations utilities and their maintenance, receive intensive study and effort to prevent deficiencies as occurred in connection therewith during World War II.

4. That suitable radio equipment and personnel be added to the Tables of Organization and equipment of all field medical units which normally operate in the Army Service area.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Earl Maxwell, MC, Air Force
dated 19 April 1948)

***** "5. The main fault found with Army hospitals sent overseas was that provisions were not made for construction of suitable buildings after the tent stage of the campaign was over. Without these provisions hospitals were still functioning in tents without floors long after headquarters personnel were living in adequate prefabricated buildings. On Okinawa this was particularly true of Army hospitals while Navy hospitals had excellent construction before they were occupied. In my opinion hospitals should all have tentage and be prepared to go in and set up immediately in their tentage, but have construction facilities available in order that suitable buildings might be constructed as soon as possible. In Okinawa, particularly, the Army hospitals were able to set up in their tentage immediately and function very well whereas the Navy hospitals were not set up to function within several months, indicating that there was something deficient in the Navy setup as well as in the Army setup.

"6. Of utmost importance in any hospital is the presence of trained plumbers, carpenters and electricians. These were woefully lacking in all Army hospitals. The medical officers could train corps men satisfactorily on the job but they could not train the above-mentioned, very necessary personnel.

"7. The medical records being dissimilar caused much confusion and necessitated placing Navy personnel in Army hospitals and Army personnel in Navy hospitals in order that Sick and Wounded Records might be kept properly. These records, of course, should be standardized so that hospitalization could take place as well in one hospital as in the other."

RECORDER
Lt Col Earl Maxwell
RECORDER

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr M.C Stayer, Major General, U. S. Army, Retired, 19 Apr 48)

****(f) Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirement.

In my experience, I saw not only the Allied Forces, but much of the enemy Medical Department organizations. I believe our personnel, equipment, and training were of the highest, and if we continue our present high standards, we will again be the leading Medical Department of the world." ****

RECORDED

L. K. POHL

Colonel, MC

TRUE EXTRACT COPY (Ltr Colonel Robert P. Williams, MC, Surgeon, 16 Apr 1948)

**** "(f) Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirement. All Medical Department organizations to be staffed with minimum number of Medical Corps Officers. But it must be recognized that some administrative or executive experience is necessary before officers can be assigned to command positions." ****

L. K. POHL
L.K. POHL

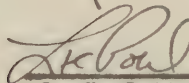
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert E. Simpson, USA (Ret.)
dated 1 May 1948)

**** (f) Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirement. This covers a multitude of problems that will change from day to day. It is suggested, however, that organizations be made as flexible as practicable, capable of being expanded, or reduced, as occasion may demand, and not rigidly bound to "Tables of Organization", etc. Training in the transportation of personnel and equipment by air may be stressed - equipment for the field may be designed or selected that may be airborne easily. There were many serious errors in the design and construction of temporary hospitals in the Zone of Interior during the recent conflict. For example, the plans for hospital buildings at a Gunnery School at Earlingen, Texas, would have been suitable for such an installation in northern Maine. This location is almost in the tropics, yet an enormous heating plant was installed including a reserve boiler. A few gas steam radiators in each building would have been adequate. According to the original plans of the Surgeon General's Office for 150 bed, temporary hospitals, there was plumbing, etc., for dental units in the Administration building, the Infirmary building, the Flight Surgeons building and, in many instances, in addition, a separate dental clinic building. The same was true as to E.E.H.&F. installation. Rooms were often too small to accommodate the equipment provided for them. Changes were not permitted during construction, regardless of how urgently indicated, but after completion, partitions had to be removed etc., and many (and expensive) changes made before the installation could be used satisfactorily. These comments perhaps should be made sub. par. (i).****



L. K. Pahl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 22 April 1948)

***** "(f) The medical department organization from the standpoint of personnel, equipment, training and mission or tactical requirement.----- The Surgeon General ought to have full and complete charge over his medical personnel regardless of the arm or service in which the individual is placed. It makes no sense to have everyone else control medical personnel except the Surgeon General and yet again and again this seemed to happen. Commanders of tactical forces had to decide on what kind of equipment they could take and invariably the medical equipment suffered because there was no one at a high level to speak for the medical department. I know first hand of no facts but more than once recall the widespread impression that the medical facilities available in certain campaigns were extremely inadequate and this was due to the bull-headedness of somebody in charge who would not accept the requirements for the medical department. Again this seemed to apply equally in the area of equipment and supplies which were under various authorities and not left to the management of the medical department. *****

Unlisted personnel, it seemed to me at least, if of marginal usefulness because of physical, mental or for emotional handicaps were often sloughed off into the Medical Department. It seemed to me that we got all of the individuals who were illiterate, incapable of even counting the number of sheets on the ward, etc. I may be paranoid about this but again and again it was apparent in my many hospital inspections.

Because of a blind spot someplace at high levels, some of our top flight medical officers were never able to admit that the greatest loss of manpower in the army was because of personality problems. For this reason the Air Corps snuffed out all of the Mental Hygiene consultation services in contrast to the increasing effectiveness of these in the basic training camps under the ASF and the HEP." *****

RESTRICTED

L. E. Pohl
L. E. Pohl, Colonel, MC

335

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel F. A. Blesse, MC, USA, dated 19 April 1948)

*****6. Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirement.

"a. Established principles were proven to be sound during the last war.

"b. Tables of organization must be constantly studied to avoid any waste of personnel. Such studies will no doubt be primarily concerned with reduction in Medical officers and it must be remembered that the requirements of units in the combat zone must be based on normal casualties expected during combat. It is usually impossible to predict when combat will occur, attacks normally depend upon the element of surprise and secrecy, unpredictable enemy action or other unexpected events may result in combat at anytime in the combat area. Therefore, the proposal, which was given wide publicity several months ago, that we should save doctors by establishing major pools of such personnel and "when combat is to take place" to promptly fly such valuable personnel to the place where they will be needed, is based on ignorance of military organization, tactics and procedures.

"c. In an attempt to obtain greater flexibility in organizations, there has been an over emphasis on the organization of small cellular teams in the 8-500 series table of organization. These numerous teams often consist of but 2 or 3 men and not only take considerable space on any troop basis but are easily forgotten and omitted. Units not approved and entered on the troop basis cannot be expected to be where required. Such units are impractical except for highly specialized personnel and should be included in Tables of Organization to insure their availability.

"d. Advanced training of Medical Service Corps officers should be considered with a view toward their possible replacement of medical officers in certain selected positions.

"e. The training of selected members of the Womens Auxiliary Corps should be considered with a view to their replacement of nurses in selected positions. Nurses will again be in a scarce category and a study of this subject will reveal many duties now performed by graduate nurses which could be accomplished by WACS if given a short, concentrated course in practical nursing. It is believed that a large number of nurses and also hospital corps men can be saved by a more proper, and more feminine use of the WAC organization. There was considerable criticism of their use as officers' chauffeurs, etc, during the last war.

RECORDED

RESTRICTED

L. K. Fehl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel F. A. Blesse, MC, USA) - Continued

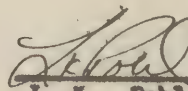
"f. The standardisation of medical equipment for the Army, Navy and Air Corps has been under constant study since the last war. The need was recognized by all three and the accomplishments of the Joint Committee on this matter are an example to others as to what can be accomplished in the unification problem. Continued study, research and development are essential and the means should be provided on a high priority. Establishments for such purpose should be unified. It would seem possible to accomplish a similar unification and standardization of supply depots in the ZI and Theater of Operations.

"g. As a policy, the normal mission of any organization must be the guiding light as to its requirements of personnel, supplies and equipment. Recommendations for additions and changes in organization tables are frequently based on unusual experiences and a disregard for the normal mission of the unit."****

TRUE EXTRACT COPY (Ltr Brig Gen Guy B. Denit, MC, Surgeon, 16 April 1948)

***** "Medical Department organizations from the standpoint of Personnel, equipment, training and mission or tactical requirement - It will take a considerable amount of imagination and pressure to convince those who have had experience in World Wars I and II in the MTO that the next war will not follow the exact pattern of the last one. Therefore, the tendency will be to build all of our Medical Department equipment, training and technical literature along the lines of that experienced in France. In this connection it is believed, that advance thinking should be initiated now and that we should keep in close touch with those who are planning the strategy and the tactics of the future Arm d Forces in order that we may not lag behind in our concepts of medical units and equipment. We do not now have suitable equipment for arctic warfare. Tentage is very little different from that employed during the Civil War. New and advanced designs are needed in practically every phase of Medical Department equipment." *****

RESTRICTED



L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel James H. Forsee, MC, USA, dated
20 April 1948)

***** "(F) Medical Department Organization from the Standpoint of Personnel,
Equipment, Training and Mission.

The only comment on this overall problem is as follows:

The establishment under the Secretary of Defense of the Office of the Surgeon General or probably better a Medical Director for Defense. This office should be a small one and function at the Secretary of Defense Level. It would not be operational. It should be policy making regarding in matters of personnel, professional policy and training. During World War I the Advisory Commission of the Council of National Defense had a member from the medical profession. This plan seemed to be a satisfactory one and the Medical Director or Surgeon General might fulfill the desirability of representation of the profession in an advisory capacity at a cabinet level insuring that the voice of medicine could be heard." *****

TRUE COPY EXTRACT (Letter, T. F. Cooper, USN, dated 19 April 1948)

***** "During the last war some twenty-odd advance base medical (G) components were developed and ranged from a 600-bed dispensary down to a rodent control unit. Each component was tailored for a certain mission. Material was assembled and each component was assigned a number. Specialized personnel were ordered and assembled as required. This greatly facilitated planning and the speed with which given operations could be accomplished. These should be further expanded. During the last war, as in all past wars, field sanitation in particular lagged far behind." *****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel John A. Rogers, MC, USA (Ret.) dated 19 April 1948)

***** "F. Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirement.

"1. In general it is believed that medical units of divisions and armies are excellent, providing the necessary degree of flexibility to fit in with a tactical situation.

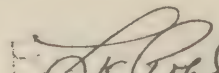
"2. The Field Hospital, with three 100 bed platoons, was a particularly useful unit. It could be used in many ways. By the addition of surgical teams and certain additional equipment, notably of a surgical nature, they were utilized as the first major army medical units shore during the Normandy Invasion. Upon the arrival of the larger Evacuation Hospitals, these units were used as Surgical Hospitals immediately adjacent to Division Clearing Stations for immediate surgery on non-transportable wounded. During the pursuit of the German Army across northern France, they were again used in effect as small Evacuation Hospitals because of their great mobility and provided very satisfactory service during this period of relatively light casualties. As the resistance of the German Army increased, they were again used as surgical units in Division areas. There has been some discussion of substituting the Surgical Hospital for this unit. It is believed this would be an error since the Field Hospital, as constituted in World War II, provides an all-purpose small unit which is suitable for many functions.

"3. The 400 bed Evacuation Hospital was eminently satisfactory.

"4. The Auxiliary Surgical Group, composed of surgical teams of various categories, was eminently satisfactory.

"5. The organization of a group of collecting companies and clearing companies at the rate of one per corps was satisfactory. During the latter part of the campaign, the commanders of these groups were used as direct representatives of the Army Surgeon, providing reconnaissance service for the forward employment of Evacuation Hospitals. The Field Hospital platoons were placed under their direct command. This provided a flexibility within the corps area which is not possible by the assignment of medical units under the direct command of the Corps Surgeon. The important fact is that it is not necessary to go through Corps Headquarters for the transfer of medical units which may be outside of a particular corps area. Clearing companies are utilized in various ways. Some are trained to handle neuro-psychiatric casualties. Others were used for contagious diseases and special situations.

"6. It is believed that the 3000 bed Convalescent Hospital would have more flexibility if it was reduced in size to 1500 beds and two provided for each army." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

**** "f. Enlisted personnel of Medical Department should be turned over to the Medical Department after their indoctrination in the School of the Soldier or basic training. They should be selected and earmarked upon reporting to a selective service board. There should be an educational minimum requirement. Equipment should conform to that of the service to which they will be attached. Their training, other than basic, should be conducted by the Medical Department of their Branch assignment.

"Officer personnel should be trained entirely by the Medical Department. As to Medical Department organization, the Surgeon General should be the general coordinator and policy making power for the Air, Navy and Ground Forces, each of which should have a Chief Medical Officer or Air Surgeon, Navy Surgeon and Ground Force Surgeon. Medical personnel should be allotted to each Branch in proportion to their strength. Each Branch should have their own station hospitals, and each Branch should have their own general hospitals. Admission of patients from one Branch to a medical facility of any other Branch should be routine and simplified. Location for the establishment of a general hospital of one Branch near a general hospital of another should be a matter for the Surgeon General to decide. At certain locations where more than one Branch are closely stationed, the establishment of a station hospital at each station should be decided by the Surgeon General. Medical personnel for the manning of a common hospital should be furnished by each Service, proportionately, but placed on detached service with the Branch having charge of the installation. Each Branch should have a Supply Division, and regardless of Branch, each medical supply point should receive and fill requisitions from all stations in the vicinity.

"Where possible, all forms, reports, requisitions, surveys, etc. should be identical for all Branches. Medical personnel should not be transferred from one Branch to another except upon their own application, approved by both Branches concerned, and then only after a period of probation. Exception being the placing on detached service of personnel with a common facility or to meet a grave emergency."****

*****Medical troops on duty with tactical units should be 'attached' to those units and commanded by medical officers. No line officer should exercise command over medical troops and Efficiency Reports on medical department officers should be prepared by medical department officers and indorsed by next higher medical authority."*****

**** "4. It is my belief that most of the transportation of troops and equipment in the next war will be via air, and to that end medical equipment should be designed with a view to the feasibility of it being transported by air."

RESTRICTED

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

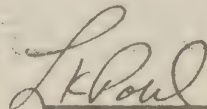
TRUE COPY EXTRACT (Letter, Colonel R. E. Stone, MC (Res.) Air Force
dated 22 April 1948)

***** "Reference Par. 3 (f) Medical Department organizations from the standpoint of personnel, equipment, training, and mission of tactical requirement.

"Always felt that the Medical Organization of the Armed Forces not sufficiently elastic to meet adequately all the exigencies of the Service.

"For Example: If the Surgeon of a large Command was compelled to rely on Medical Department Personnel authorized by Tables of Organization as used in the last war, many of the units would be without adequate Medical coverage. In the E. T. O. there were many small units attached to the Air Force for which no Medical Personnel provided by current Tables of Organization. The aggregate of these units added up to a sizeable force for which some provision for Medical coverage had to be made. It would be my recommendation that some provision be made in a Tank Force whereby the Command Surgeon would be furnished a reasonable number of Medical Department Personnel over and above Table of Organization authorization to meet these requirements. This could be in the form of a Casual Pool directly under the control of the Command Surgeon. In this way he could shift his personnel expediently to meet the day to day demands. Such a pool was provided the Air Force in the E. T. O. but this was not a recognized unit, there was no Table of Organization which allowed for promotion of those worthy of advancement with the inevitable development of poor morale in this group.

"Serious consideration and study should be given to the Medical Service as organized in the Royal Air Force. In that organization the Chief Medical Officer could place and transfer his personnel about as he saw fit. This made a very flexible organization and I feel that personnel generally utilized to better advantage. Am also of the opinion that such a system in the long run would actually conserve personnel. Too often an individual with certain qualifications was needed by the Surgeon for special duty but when his services requested more often than not he was declared by the lower echelons as not available. Certainly a surgeon with the over all picture in mind should be in a better position to judge where any one man's service best utilized and his desires to get a job done should not be blocked by so called 'Command Prerogative'."




L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Robert E. Peyton, MC, USA
dated 19 April 1948)

"****Tables of Organization and Equipment. It is recognized by all thoughtful persons of experience that there is much that can be accomplished in improving tables of organization and equipment. We can make many improvements, thoroughly and gradually, with the full knowledge that everybody will not always be pleased. Only the novice with narrow perspective has the audacity to admit that he is endowed with superior knowledge on this subject, and he usually further confuses the issue by contradicting himself by every other criticism he makes! A realistic approach to this problem is necessary: first, because the ambitious T/O&E reformer ascribes to the unit commander only the negative virtues; second, because no table can be made to suit the unknown individual personalities who fall by change into its organization; and third, jockeying for position will occur between the medical, surgical, neuropsychiatric, and laboratory specialists, and even within these groups. Mobilization troop bases (and the tables of organization and tables of distribution or bulk authorizations of which the troop bases are composed) require constant study and revision in the light of the national manpower resources to be made available to the armed forces. If it is found, for example, that the number of doctors made available to the armed forces is less than that which will provide for adequate manning of the tables to insure acceptable military medical standards, then it is necessary to make the fact known. That is a matter of national responsibility.****"



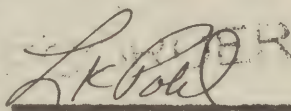
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTEDTRUE COPY EXTRACT(Letter, Captain O. B. Morrison, Jr., MC, USN
dated 23 April 1948)

***** "f. Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirements.

There seems to be a tendency to maintain in time of peace, the same types of organization as was used in time of war. There may be some logical reason why this is considered necessary, but there are many reasons why it should not be done. As an example, a Marine Division at present has to have a Medical Battalion because it is claimed that the Division must be organized and available to move to a trouble zone on short notice. However, the medical personnel have little or no professional work other than routine sick call dispensary duty. The result is deterioration and discontent of such medical personnel. It is suggested that such personnel could be more efficiently employed in nearby hospitals where they are needed and could be employed in accordance with their medical training. The medical officer in command could assign the personnel required on a rotational basis so that sick call could be properly covered in the area dispensaries. In time of emergency the Medical Battalion could easily be formed by drawing personnel from the hospital staffs. Equipment could be kept up better because it could be utilized and replaced as required instead of deteriorating in storage. " *****


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Arthur B. Welsh, MC, USA
dated 19 April 1948)

***** "f. There were too few mobile hospitals of the 750 bed evacuation hospital type. The Army Ground Forces were responsible for getting such units into the troop basis. They failed. Urgent pleas of The Surgeon General and the Army Service Forces for additional units never got into the troop basis! There were also too few 400 bed evacuation hospitals. Such planning forced theater surgeons to misemploy general hospitals. They had no other alternative for Advance Section hospitals.

"Mobile surgical hospitals were non-existent until the end of the war and during the war had to be improvised from platoons of field hospitals reinforced with special personnel and equipment. This was a planning failure of Army Ground Forces that The Surgeon General could not correct which was equally true of the two platoon divisional clearing company.

"There was no suitable hospital for the Advance Section of the Communication Zone in rapidly moving situations except possibly the field hospital which was not designed for that purpose. Suitable construction for Advance Section fixed hospitals was not provided.

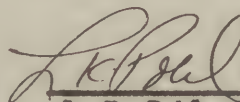
"There was insufficient holding capacity in the Combat Zone and units for holding purposes at transfer points came too late.

"Numbered station hospitals very frequently had to be employed as general hospitals. They were not staffed qualitatively to do that job and there was very little that theaters could do about it. Thought should have been given by The Surgeon General to melding numbered station and general hospitals into 'fixed hospitals, communication zone' and staffing them quantitatively and qualitatively to handle their indicated patient capacity. This was a problem in the Pacific.

"Insufficient attention was given by the Army to amphibious training in conjunction with the Navy. Casualty handling should have received greater stress. It seemed as if the Engineer Special Brigade received too much attention at the sacrifice of other units that might have been employed in joint medical training.

"It was a mistake to break up medical regiments and battalions and activate separate companies for hit and miss assignment to various group or battalion headquarters. The price was paid in loss of morale and esprit de corps among medical troops. Field medical service suffered. We hear little today except about evacuation hospitals in the combat zone.

RESTRICTED



L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT - Continued - Colonel Arthur B. Welsh, MC, USA

"In the eagerness to save Medical Department personnel too many non-medical separate companies and battalions were shipped to theaters without accompanying medical personnel. This placed a burden on theater surgeons who had to supply medical personnel from other units for dispensary service. It's true that 8-500 series cells might have been used had bodies been made available.

"There were too few doctors authorized for numbered general hospitals. The authorized grades were too low ranking for the professional caliber personnel required for such duty.

"It was a mistake not to give theater surgeons Medical Department personnel pools. It's questionable whether evacuation hospitals should remain fully staffed when not actively engaged. Pools and theater control over technical means would have assisted in solving this.

"The pre-activation training of personnel for numbered units as originally conceived and employed by The Surgeon General is the key to meeting overseas demands for medical units. A communication zone medical unit, for example, can under such a scheme be put together, enlisted specialists, doctors and nurses added (quantitatively and qualitatively) and shipped to the port within thirty days and function creditably upon arrival overseas. Had such a scheme been universally followed less criticism of doctor wastage would have arisen.

"Too many overseas theaters asked for units before they were needed. This is understandable in long range planning. Too, theater surgeons weren't sure such units would be shipped in time. This explains in part that often heard remark -- too many doctors with too little to do. One can't afford to be critical because the medical job was well done. There were many intangibles. A better solution is hard to plan in view of World War II armed forces structure. It's inconceivable how a better theater job could be done. If there had been an Armed Services of Supply setup in the zone of interior with top side guidance and definite medical responsibilities for all Services inherent therein and liaison with the General Staff and Joint Chiefs of Staff assured there would have been very little medically that could not have been accomplished worldwide. This would call for the highest degree of medical leadership.

RECORDED

L. K. Pohl

RESTRICTED

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT - Continued - Colonel Arthur B. Welsh, MC, USA

"Medical supply was well handled. More attention should have been given to complete unit assemblies and there should have been minimal split shipments.


"Insufficient attention was given in the early phases of the war to the convalescent and rehabilitation programs. It was faulty zone of interior planning at higher than War Department level.

"Auxiliary service personnel and equipment for laundry, utilities, and maintenance in hospitals was not provided." *****

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus, (MC) USN dated 27 April 1948)

***** "(f) - It is not clear what is meant here by 'Medical Department Organizations'. If these refer to the Bureau of Medicine and Surgery, Naval Hospitals, Convalescent Hospitals, dispensaries, Hospital Ships, sick bay facilities, Research Facilities, Medical Supply Depots, Medical Storehouses, Schools, Medical Departments with marines and in aviation, it is felt that in the overall there is little basis for controversial opinion regarding their effectiveness in carrying out the mission of the Medical Department of the Navy, and meeting tactical requirements. It is believed that the 'What' was needed to fulfill our mission was provided. The 'How' it was accomplished may be subject to controversial opinion regarding certain specific features of the total effort. General statements such as those made above do not imply that there were not many lessons learned through experience in World War II that should not be repeated in the event of future emergency and it may be assumed that they will be taken into account in current planning. Detailed comment here would be most difficult without a better idea as to what the controversial points may be." *****

RESTRICTED


L. K. Pohl, Colonel, MC

346

RESTRICTED

TRUE COPY (Extract "tr Quinten M. Sanger, BUMED, USN, 15 April 1948)

****The incompleteness and inadequacy of hospital clinical records was pointed out. It was proposed they be studied with a view to standardization, simplification and improvement of form, method and nomenclature.

The Special Augmented Hospitals used during the war were intermediate between the Marine Corps field hospital and the Navy's fleet and base hospitals. They met varying criticisms.

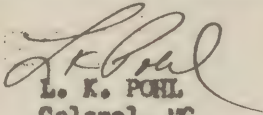
They were planned to provide hospital facilities in proximity to combat areas. The following was said of S.A.H. No. 8. (Okinawa).

"If it was intended that this hospital should be in operation to function during the active campaign for the island, then its equipment and construction contained too much of a semi-permanent or permanent character so that it could not be erected quickly. On the other hand, if it was intended that this hospital should come into operation after the termination of hostilities (as actually happened) then its construction of too temporary a character to afford comfort and efficiency."

A lack of special floor space or rooms for persons with certain kinds of diseases and operations, for officers, for convalescent patients, and for examinations, was probably the most persistent deficiency of the medical and surgical departments aboard ship.

Facilities for psychotics were inadequate. There was not enough space. Sometimes there was no segregation, or they were kept in the brig. This was especially true at advanced bases.

Civilian workers, construction groups, etc., at naval stations required a great deal of hospitalization, more perhaps than the Medical Department planned for or anticipated. Such hospitalization needs should be taken into account in planning medical personnel and other hospitalization requirements."****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain H. B. Tomblin, MC, USN
dated 23 April 1948)

***** (F) MEDICAL DEPARTMENT ORGANIZATIONS FROM THE STANDPOINT OF
PERSONNEL, EQUIPMENT, TRAINING, AND MISSION OF TACTICAL RE-
QUIREMENT.

As previously noted, the military mission frequently alters the support required of medical organizations accompanying any military movement. The close coordination of the various components of the invading forces was most apparent toward the close of the last war. The extensive planning and thorough investigation of all problems which would contribute to the success of the operation was thoroughly studied and well understood by all who had a part in the execution of the plan.

Medical organizations were accorded equal consideration, and it was to the credit of the medical department as a whole that well-trained and qualified senior officers contributed much to the organization of various medical units. The planning of the Okinawan campaign was one of varied and extensive magnitude which required the services of medical personnel accompanying troops, followed by adequately equipped field hospital units, corps evacuation hospitals, LST(H)s, hospital ships, air evacuation facilities, and later, the setting up of special augmented hospitals. In addition to the above-noted various type units, the military government hospitals certainly must be included, as well as the medical units attached to the construction battalions.

One readily appreciates that the medical and surgical assistance provided by these various organizations was of varied character, and it is to the credit of each organization that they performed their assigned tasks in a highly commendable manner. Their equipment was entirely adequate and all medical department personnel demonstrated a complete familiarity with its operation.

As I previously stated, this last major campaign represented the results of good planning, adequate equipment, and the employment of seasoned and well trained personnel, and it demonstrated most clearly the absolute necessity of a thorough consideration of all factors before attempting to mount such an assault.

No one medical department organization could be singled out as contributing more than others to the success of the Okinawan campaign, but it was clearly apparent that every unit cooperated to the greatest extent in maintaining the lowest morbidity rate possible. The whole blood unit was most successful in providing adequate quantities of blood, the LST(H)s

RESTRICTED

RESTRICTED

worked in perfect accord in the receiving of battle casualties from the beach, and passed their cases along to the hospital ships. The field hospitals operated most successfully in screening all cases, and moved those of a more serious nature to the evacuation hospital, from where they were evacuated by plane and ship to the zone of communication.

This sketchy review of only a few of the successful accomplishments of the medical department organizations on Okinawa clearly demonstrates the real necessity for the specialized training, selection, and equipping of medical personnel for various phases of a military operation." *****

RESTRICTED

L. K. Pohl
L. K. Pohl, Colonel, MC

349

RESTRICTED

TRUE COPY (Extract from Ltr W. H. Michael, Rear Admiral (MC), USN Retired)

**** "The Navy Medical Department units (ranging in size beginning with the first aid units to general hospitals) from the standpoint of personnel, equipment and mission worked out fairly satisfactorily in some cases; but much time, personnel and material was wasted in others by so-called "staging" for long periods. In these the need for the units was not estimated or badly estimated. It is suggested that the personnel of these units be kept at a minimum, sufficient to care for material, and then additional supplied a short time before the prospective need in keeping with the actual mission to which the unit is assigned. Then the personnel should be decreased or augmented as the situation dictates. There is a tendency of units to take root and become permanent long after the real need for them has passed. This must be combated.

"If I may presume to criticize an Army unit, I would suggest that the Army Hospital ships be equipped and be prepared to act as a temporary base hospital while in port and not limit its utility to the transportation of patients." ****

RECORDED
L. K. Pohl
L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee, dated 18 April 1948)

***** "(f) Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirement.

"The Medical Department should be completely re-organized and re-equipped in the light of modern air and motor transportation. All hospital equipment for field use should be designed to be airborne. Every use should be made of the techniques of air evacuation and air transport of medical personnel. Tremendous personnel saving could be achieved by this. During the past war, at any given moment, about 1/3 of the medical officers were travelling. An air-borne medical establishment should be the ultimate objective. With this, a revision of specialty is badly needed." *****

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extracts from Ltr Col. Harry G. Armstrong, MC, 16 April 1948)

**** "f. Medical Department Organizations from the standpoint of
Personnel, Equipment, Training, and Mission or Tactical Requirement.

(1) Defects:

- (a) Medical Department organization too rigid.
- (b) Equipment in general, too heavy.
- (c) Training inadequate for conditions met in actual combat.

(2) Remedies:

- (a) Use pools of doctors to cover medical requirements by means of airplane transfer.
- (b) Proportion dental personnel to population rather than T/O.
- (c) Modernize medical equipment.
- (d) Specialized training of personnel for specific assignments only, such as atomic blast casualties, or BW."

L. K. POHL
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr Alfred W. Eyer, Captain (MC), USN, 17 April 1948)

**** "(f) Medical Department Organizations from the standpoint of personnel, equipment, training and mission or tactical requirement.

"Specialist training for medical service personnel recently graduated from medical schools is not regarded as sound from a service standpoint.

It tends to bracket the young man in a relatively narrow path prior to development of his capabilities as a physician. Such development is gained only by general medical and surgical experience with a wide variety of patients.

Further, the utilization of a young specialist without breadth of experience and development of his full capabilities imposes a serious limitation upon the freedom of action of the respective medical services in meeting general service requirements.

Broad Bureau policy with regard to personnel, equipment, training, mission and tactical requirements should be clearly enunciated and not subject to frequent major fluctuations. An effort should be made to indoctrinate, not only regular service personnel, but potential inductees as well. This latter might be accomplished readily by joint service efforts through lectures delivered at medical training institutions.

More emphasis should be placed on training all categories of medical service personnel for war. It appears at the present time that emphasis is being placed on peacetime service. Much could be accomplished by thorough indoctrination of personnel in the added responsibilities that are incumbent upon in various situations during war service. Particular reference is made to sanitation as applied to forces in the field. This function showed many discrepancies during the last conflict which were due to lack of appreciation by both general service and medical personnel of its importance."

RECORDED

L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Robert M. Gillett (MC) USN
dated 15 April 1948)

***** "The medical department organization during World War II was severely handicapped by lack of adequately trained personnel on staff jobs, who had little or no knowledge of the military problems, and were not taken into confidence by their Commanders during the planning stages." *****

RECEIVED

L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Captain J. H. Robbins, (MC) USN dated 26 April 1948)

***** "It is believed that there was too much over-emphasis placed on specialization of medical officers. Basically the staff of these hospitals should be regular officers for command and executive positions and in hospitals of 1000 to 1500 beds a third regular officer of sufficient rank and experience should be made available as head of the Professional Department and under him a Chief of Medicine and a Chief of Surgery, (specialists in their line), X-ray specialists, skin specialists, Eye, Ear, Nose and Throat specialists, Psychiatrists, etc., while the remainder of the staff be made up mostly of men with general experience. The lack of general men throughout the entire South Pacific was especially noticeable as the Bases decreased in size and the personnel were moved forward, it became an extremely difficult matter to find an individual who was capable of doing an appendectomy and looking after the general run of patients seen at sick call. This necessitated keeping two or three specialists tied up on a small Base at a time when their services were sorely needed in the forward areas.

"The policy of turning trained malaria control and sanitation units loose on their own in an area was especially bad as they met considerable opposition in certain units where their services were badly needed. It is recommended that these units be placed under the direct command of the Senior Medical Officer of the area who had authority to see that their work is carried out by the unit and overcome any opposition." *****

RECEIVED

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel O. F. McIlroy, MC, Air Force
dated 20 April 1948)

***** "f. It is considered that a great saving in professional personnel could be accomplished by a change in Medical Department organizations, aimed at permitting physicians and surgeons to devote practically their entire effort to the care of patients. It is the firm opinion of the undersigned that proper organization would permit these professionally qualified individuals to be taken from civilian life and placed directly into medical facilities with little or no military indoctrination. In fact, the prospective shortage of medical officers makes it appear that some such reorganization will be necessary during peacetime in order that the mission of the medical service may be properly accomplished. This scheme involves the employment of non-professional officers and non-commissioned officers in such a manner as to relieve the majority of medical officers of all administrative responsibilities and place them in much the same position as they occupy in civilian hospitals. It is realized that some experienced medical officers must be utilized in administrative positions, such as that of Commanding Officer of a hospital, in order that the organization may profit from his professional knowledge. It is believed, however, that with these and certain other exceptions, the medical facilities can be efficiently administered without involving physicians and surgeons who frequently have no liking or ability for administrative duties. Freeing these individuals from administrative duties in order that they may devote their entire effort to actual care of the sick and injured would permit them to function efficiently with little or no military education, would permit them to assume the responsibility for the care of a great many more patients, and would thereby produce great economy in the use of our medical personnel resources. In order to more fully clarify the concept of the undersigned, it is added that this organization would free the average medical officers of any responsibility in regard to the operating or care of medical facilities. For example, in a peacetime hospital no doctor would have anything whatsoever to do with the care and cleanliness of wards or with the supplies and equipment. All such things will be responsibility of non-professional personnel. This same policy applied to wartime medical facilities of all types is the concept of the undersigned. The resultant saving of professional personnel could be increased by extending this concept to 'front line' medical organizations. In the past, such professional

RECORDED
[Signature]

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

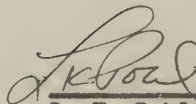
TRUE COPY EXTRACT - Continued - Colonel O. F. McIlroy, MC, Air Force

personnel has been wasted through the assignment to military organizations where their functions are somewhat similar to those of a fire department. In other words, they are often with exceedingly little to do and the excuse for this is that they must be there in case of some type of catastrophe. A greater utilization of non-professional Medical Department personnel for first aid functions, improved systems of evacuation, and the organization of combat surgical teams which could be rushed to places of need, would accomplish the same task with expenditure of much less professional personnel." *****

TRUE COPY EXTRACT (Colonel Hervey B. Porter, MC, USAF, 23 April 1948)

***** "f. Greater flexibility from Central Pools of personnel and equipment for loan to commanders concerned under conditions requiring greater resources than their own T/O & E." *****

RESTRICTED




L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY (Extract Letter Quinton M. Sanger, BUMED, USN, 7 April 1948)

*****"As long as Medical Corps assignments are primarily determined on the basis of full-complement ratios, command-rank ratios departmental-command ratios, etc., we shall face As good medical care becomes more complicated and consequently focused in hospitals, and as transportation of medical emergencies on land and sea has been developed, it's felt that the per capita allocation of medical officers is outmoded, and that complements need revision according to professional rather than numerical coverage."*****



L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Brig. Gen. Robert C. McDonald, MC, (USA - Ret.)
dated 15 April 1948)

***** "(f) Medical Department Organizations from the standpoint of personnel, equipment, training, and mission or tactical employment.

"(1) Comments: Medical organizations were generally overstaffed at the beginning of W.W.II. They were generally understaffed at the end of hostilities. The specially qualified personnel available had to be spread thin enough to man all organizations. Medical equipment was adequate in most organizations. The development of special equipment for jungle warfare was outstanding. The development in peacetime of special equipment needed in Arctic climates is most valuable and timely. The training of Medical Department Personnel was well organized; and generally well done. The tactical employment of Medical Organizations was well planned and carried out.

"(2) Suggestions: Special attention should be given to developing medical organizations and equipment adapted to warfare involving the use of newer weapons such as atomic bombs, bacteria, etc., and in Arctic warfare."*****


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Letter from Capt. Warwick T. Brown, (MC), USN
dated 20 April 1948)

***** "f. Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirement.

Medical Department personnel assigned to the combat zone should be physically capable of standing the hardships they will encounter. In general, this qualification is more characteristic of the younger men but not necessarily so. The training required has been commented on under sub-paragraph (b) and it is again stressed that military training for a selected few in the grades of Lieutenant Commander and Commander at the level of staff and command schools is absolutely essential to the satisfactory functioning of Medical Department organizations in combat. To restate this principle, all medical officers and chief petty officers assigned to field or amphibious medical organizations should have a limited amount of training in field and amphibious medical technical schools so that they may become acquainted with the organization, its tactical employment and equipment, while a few medical officers should be trained for command and staff functions. This latter group will serve as Force Surgeons, Corps Surgeons, Division Surgeons, Transport Group Medical Officers, Medical Battalion Commanders, and in the medical sections of the various senior Staff Medical Officers. Field Medical Equipment should be subject to constant revision to keep abreast with newer materials and designs and with the contemplated tactical employment of troops. In this connection we should not get too far ahead into the hazy realm of the atomic age as practical considerations indicate that the organization, equipment, and techniques of World War II will be employed in any war that might arise within the next few years. Navy medical field equipment was particularly well adapted to amphibious warfare but there is ample room for improvement in this field. In the past there never has been sufficient money available for proper experimental work. Improved portable plywood operating rooms and other field hospital housing of a light type should be developed. Operating room trailers such as the Marine Corps now possesses warrant further investigation and development by the Medical Department. *****

RECORDED

L. K. Pohl
Colonel, U. S. Army

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M.J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

***** "(f) Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirement.

Under this heading my remarks must be brief. I consider that the numerous and varied medical units or organizations represented careful thinking, planning and execution. It seems to me, that we just about had on the spot what was needed insofar as medical organization was concerned. Operational activities naturally proceeded more efficiently and expeditiously as time went on. Undoubtedly improvements could be brought about in the future, but I am aware of no fundamental and basic faults in the type of these organizations and personnel equipment training and the mission to which they were assigned. Undoubtedly more than one instance occurred which could come under constructive criticism. I have in mind a so called Mobile Unit which had been destined for one of the forward areas but due to the conditions of combat, was required to base in an area already supplied with adequate medical services, and subsequently fell apart, losing its identity as a result of various subtractions and depletions to which it was subjected. Our so called Mobile Hospitals, Cub, Lion, Acorn, and similar medical organizations as well as our fleet hospitals served well and most efficiently.

Concerning the value of hospital ships it may be here that I am a bit prejudiced. Our ship was the only hospital ship in the Pacific for more than sixteen months. Some time later the Pacific Ocean was to become liberally dotted with such vessels. They all did a bang-up job. They were in reality the only truly mobile hospitals that we had, possessing fine materiel and personnel equipment. They were able to give definitive treatment to our sick and wounded while en route to the evacuation hospital. In my opinion these ships will play an important role in any future war in which this country may engage. Much of the same can be said concerning our hospital transports like the Rixey and Tryon. Most of our hospitals in the continental areas were general in type, yet as time went on certain of them developed singular and special features. I have in mind amputee centers, centers for the blind, hard of hearing, paralyzed groups, mentally ill, etc. These special facilities proved their worth.*****

RESTRICTED



L. E. Pohl, Colonel, MC

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E. R. HARRING, JR., (MC) USN ON 22 APRIL 1948 AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

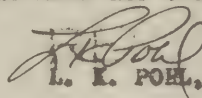
***** F. "I am sorry I didn't bring along a letter which I wrote 1-1/2 years ago, which, as far as the Marine Corps is concerned, I think will be the answer, and that is the establishment of a sanitary medical company in the medical battalion.

These people must be under the control of the medical department. They can have no other function. Such a company would be of two platoons, one platoon being similar to the material control and epidemiological control, which we have now and which is excellent, and the other company being the strong back to do the work -- but even to do that work it needs more than a strong back. They must have the equipment and they must be trained to maintain that equipment and use it properly.

My recommendation at that time was for merely about 30 men in charge of a sanitary engineer to actually do the major sanitary measures necessary, such as clearing up swamps and mosquito breeding areas, spraying the dead carcasses and destroyed food dumps and destroyed sanitary installations, and so forth.

Medical Department Troop Allotments in Proportion to other Branches as Influenced by Probabilities of Atomic Warfare. I don't feel qualified to answer that, except from my concept of the way the Marines are organizing their forces in the event of atomic warfare.

I would not have any more increase in the medical people among the combat elements. Rather, it appears to me, it is just a terrific problem in the rear areas where we could evacuate to. There again, we need air evacuation to get these people out." *****



L. E. POHL, Colonel, MC.

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Letter from Colonel Richard T. Arnest, Ret.
dated 19 April 48)

***** "f. This is a big subject and cannot be fully discussed here.

The small mobile surgical and 400 bed evacuation hospital should be utilized with division and corps while the large 750 bed evacuation hospital should be reserved for the army either as a two week holding unit for return to duty cases or for evacuation to the rear. These hospitals should be staffed in accordance with requirements and not by a fixed T. O. except for key personnel. This key personnel should consist of the Commanding Officer, Chief of Services, and the Administrative Staff. Doctors do not require extensive field training for any of the tactical hospital units nor do they for hospital in the zone of communication or interior. For combat troops one medical officer per Bn. is essential and one as Regimental Surgeon. The remainder of the officers can be well trained special service corps. Entirely too much time was spent training medical officers and nurses when in fact the largest percentage of them were only utilized in their profession.

I noted few deficiencies in equipment for hospital units that could not be corrected by theater headquarters. The table of allowances should be flexible and not considered fixed, thus permitting additions or subtractions as the mission indicated." *****

RECORDED

L. K. Pohl
L. K. Pohl
Colonel, U. S. Army

TRUE EXTRACT COPY: (Ltr N. C. Mashburn, Colonel, MC, Air Force, 19 Apr 1948)

*****"Medical personnel should wear the uniform and be completely identified with units they serve."*****

L. K. Pohl
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** (F) 1. Yes. I think in many instances it was necessary to attach additional medical units to combat medical units to carry out their assignments. I am referring particularly to clearing companies, collecting companies and ambulance companies. Specifications were based on normal loads.

"2. Some were but most weren't. I hesitate to say a longer period of training in the States. I think they could be trained overseas while they are in staging areas. I don't believe wastage actually would occur if they are trained overseas because they are like everything else, there is some wastage to it and I would rather it be overseas than in the States because the training is better overseas because of overseas command having a greater cognizance of the problems they are actually up against.

"3. The generators were not big enough - there were not enough trucks. Practically all had to be supplemented in their messes. Were it not for the civilian population and prisoners of war for mess attendants they couldn't have gotten along.

"4. I think that it should. It should be mandatory. In some instances equipment did not arrive until 60 to 90 days after the arrival of the personnel. Personnel had to remain idle in debarkation ports. Hospital ships should be constructed so that medical equipment equivalent to a general hospital could be stored in the hold. More utilization of personnel in transport should be used."*****

***** "6. No. Medical units should be provided for medical cases in forward areas because the evacuation hospital equipment is too specialized. As atomic warfare, I believe the unit that takes care of gas warfare might have some idea about it, but if it is widespread medical installations should take care of them the best they can."*****

***** (G) 9. I think they were necessary for psychological reasons but not for professional reasons. I do not think so. Females hampered movement of units and reduced mobility of units."*****

RECORDED

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 Apr 48.

***** P. "I would like to see additional personnel allowed where we care for dependents in our hospitals and in outpatient clinics. We know from a professional standpoint that it is much more desirable to have dependents in our hospitals because we have much better rounded service. But women and children require more nursing care than male patients, at least care that is given by women nurses, and those people are usually hospitalized only during acute illnesses. They go home after they are able to be up while our soldiers are around in the convalescent stage. You might say the bed is occupied. What difference does it make if the bed is occupied by a soldier or by a dependent? It does from the amount of nursing work that a woman nurse does for women and children and the number of things that have to be done for them.

BRIGADIER GENERAL MARTIN: In your opinion, were medical department units sufficiently staffed with nursing personnel; that is, to include both mobile and fixed units?

COLONEL PHILLIPS: Well, just from comments that we received -- as I say, I had no experience with the operation of these units during the war -- they got along. They gave good nursing care, but I think they felt the distribution was not as it should have been; and, in some places, they were greatly overworked while other places had too much personnel.

The staff that we had to come down to here at home was one nurse to fifteen beds, which was not adequate, and one to twelve overseas. We had to turn over duties, that we felt we, as nurses, should have performed and would liked to have performed, to subprofessional personnel and other groups that we could get, but it was an emergency situation and we did the best we could, just as the civilian hospitals did.

BRIGADIER GENERAL MARTIN: In your opinion, did the presence of nurses in field medical units prove worthwhile?

COLONEL PHILLIPS: Indeed! I think the record speaks for itself.

BRIGADIER GENERAL MARTIN: Would you say that most of the success was due to professional attention given by the nurses or their presence acting as a psychological factor?

COLONEL PHILLIPS: I think both were very important. The psychological effect certainly was important, but the professional care that they could give to the wounded soldiers as far forward as possible, I think, was the great factor. The morale of those nurses, too, was very, very high. They didn't want to go back to the rear echelons, and the people in the rear echelons wanted to get up where they felt they could take care of them.

BRIGADIER GENERAL MARTIN: Do you believe that an organization, such as the WAC, could have replaced the more or less civilian character of the nurses' side?

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC. 27 Apr 48. CONT.

COLONEL PHILLIPS: The advantage of having the WAC was that she was there or we knew where she was. Of course, with our civilian nurses' aides, if they agreed to come on, they were with us. Other civilian personnel are not as dependable as to their hours of duty. They may show up, and they may not. The WAC personnel are militarized. So they are either there or we know they are sick in the hospital.

COLONEL POHL: I wonder if you care to mention or make any comments with regard to usage of nurses in air evacuation and the training that was given them -- necessity or desirability, or whether there was wastage in that regard.

COLONEL PHILLIPS: Oh, no, there wasn't wastage! I think they had a very fine course. It was operated at Bolling Field, and I think those people were very well utilized. I certainly don't think they were wasted. They may have been used -- I don't know how they were assigned, whether they were used for longer periods of time or not. I knew some of them had long service over in the HTO and later over in the Pacific Theater. That program is a very necessary program, I think.*****

RECEIVED
L.R. POHL, Colonel, MC

TRUE EXTRACT COPY (Ltr Brig.Gen. G.R.Kennebeck, Dental Corps, dtd 7 May 48)

***** F. "Definite hospitals should be equipped, staffed and trained for the treatment of jaw injuries so that medical and dental team work can be employed and efficient treatment given this type of patient."*****

RECEIVED
L.R. POHL, Colonel, MC

RESTRICTED

RESTRICTED

**TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE MEDITERRANEAN THEATER
HISTORICAL SECTION - AFTAS**

***** V. "Throughout most of the year 1944 a considerable effort was made by the Surgeon, Army Air Forces, Mediterranean Theater of Operations, to obtain Army Air Forces Central Medical Establishments for the Twelfth and Fifteenth Air Forces. A plan drawn in Headquarters, Army Air Forces, was transmitted to the Surgeon, Army Air Forces, Mediterranean Theater of Operations, in February 1944. The plan, later incorporated into a Table of Distribution, envisaged an organization composed of 10 officers and 25 enlisted men and divided into four sections; Headquarters, Central medical board, Aircrew indoctrination, and Aviation medicine. It was designed for attachment to an Air Force in a theater of operations in order to provide special aeromedical services that the headquarters medical section of an air force was not equipped to furnish. The theater Air Surgeon expressed a desire to inaugurate such a program in the theater, but owing to the fact that sufficient grades and ratings to organize a Central Medical Establishment did not exist within the offices of the air force surgeons, he wrote to The Air Surgeon, Army Air Forces, requesting further information and advice regarding the matter. In reply, the Air Surgeon stated that no Central Medical Establishments were available for deployment in the Troop Basis; and he recommended that, if it were impossible to inactivate a sufficient number of units within the theater for this purpose, the theater commander should be furnished with a detailed summary of the need for a Central Medical Establishment and the services it would perform "in order that the War Department might be informed directly from the Theater of the conditions which made this type of unit essential". In conformity with this suggestion, a letter outlining the need for this unit was prepared by the Surgeon's Office, Fifteenth Air Force, endorsed by the theater Air Surgeon, sent direct to Headquarters, Army Air Forces, and referred to the Air Surgeon for action. Efforts of the Air Surgeon's Office in September and October to secure authorization of personnel for a Central Medical Establishment for the Twelfth and Fifteenth Air Forces from the Zone of Interior were unsuccessful.

It was felt by many surgeons that Table of Organization ratings of medical and dental enlisted men performing technical and administrative work were not commensurate with their duties. Medical enlisted men were dissatisfied with their ratings in comparison with those individuals in other branches of the Air Forces, and dental enlisted men and some dental officers thought that they were discriminated against in the Tables of Organization in comparison with medical enlisted men and members of the Medical Corps.

An effort was made in the Twelfth Air Force to base promotions of Medical Department officers as far as possible on merit as well as length of service, a policy that caused so much dissatisfaction on the part of some individuals that they chose to transfer to Ground Force units. In general, the ranking officer of a unit was chosen for any new assignment that might lead to promotion; thus an opportunity was created whereby the officer next in rank might become surgeon of the unit. The Air Force Surgeon disapproved of a practice that had been found unsatisfactory in the Ninth Air Force, namely, that of persuading the commanding officer or enlisted men beyond Table of Organization allowances for the medical section at the expense of other branches.

It was foreseen that this procedure would likely lead to a request for the reassignment of such overages by a new commanding officer, as well as general dissatisfaction on the part of nonmedical personnel.

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE MEDITERRANEAN THEATER
HISTORICAL SECTION - APTAS, CONTINUED

The reverse of this practice, however, was apparently not entirely absent, especially with respect to enlisted men. One wing surgeon noted with displeasure that ratings authorized the wing surgeon's office by the pertinent Table of Organization were appropriated by other section of wing headquarters. A similar situation with respect to the squadron medical sections of an Air Depot Group existed over an extended period of time.

When plans were being made for the invasion of North Africa, it was foreseen that there might be a dislocation of large numbers of troops from the units responsible for their medical care. To supply this deficiency the Medical Detachment Dispensary, Aviation, was devised. Since no Table of Organization for such a medical unit existed, a manning table was set up authorizing two officers (including one Dental Corps officer) and eleven enlisted men. The equipment that most nearly met requirements was that of the Air Base Group Aid Station.

In the interim they operated under great difficulties with equipment and supplies procured from whatever source available. In the forward areas, owing to frequent enemy air attacks, they were located underground. Wood for heating water and other supplies had to be procured at a distance of from 10 to 15 miles at night by detachment men. However, in spite of these difficulties their usefulness was unquestionable; in fact, according to one observer writing in March 1943, "the most completely satisfying and useful medical unit with the Air Forces in this theater is the Aviation Medical Dispensary."

RECORDED
L.H. FORD, Colonel, MC

RESTRICTED

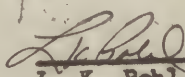
RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT
HISTORICAL RECORDS OF WORLD WAR II. (1st Bombardment Division 44)

"A succinct and shrewd analysis of the picture in a bombardment group is illustrated in the following quotation from the writing of one of our Group Surgeons: 'From the standpoint of the number of personnel to be cared for, the rank of the unit surgeon is certainly adequate, but in order to be of most value in his staff positions the unit surgeon should be one grade below that of the unit commander. For example, if the Commanding Officer is a Lt. Col., and the Squadron Surgeon a Captain, along with dozens of Captains of various branches, especially Air Corps, and these Captains are not comparable to Squadron Surgeons in age, education, or attainment, and in most instances are their junior in point of service, the tendency is to underestimate the capabilities of the Squadron Surgeon, particularly by the young officer who has attained the same military position five or ten years before the Squadron Surgeon... Also there is a tendency in military life for rank to be associated with rank and the contrast in this case seems to be a bit too great. Inasmuch as the position and value of the medical officer depends almost entirely upon his liaison with command rather than his professional ability, it is felt that an approximation of rank would make his services more equitable to the organization.' The author suggests also, that the medical enlisted man be rated correspondingly in his rank in the military community. Altho the quotation covers the bombardment station situation very adequately it does not touch on the Division Headquarters organization." *****

***** "The one unfortunate oversight in T/O for enlisted men seems to have occurred in the Headquarters Squadron of a Bombardment Division. Altho the station strength constantly runs in the neighborhood of 1000 persons, only five medical enlisted men are authorized the Headquarters Squadron to care for this large number. It is recommended that the enlisted men authorization in any new T/O be proportionate in strength to the Bomb Group, both as to number and rank. This situation was corrected to some degree in September 1944 by changes in T/O of Bomb Groups, allotting the majority of the medical enlisted personnel to the Bomb Group Headquarters and leaving only five each to the Squadrons. Since this change occurred almost concurrently with the assignment of the Medical Dispensary, Aviation, (RS) and the dissolution of the medical personnel average in the Station Complement Squadron the net result in functional organization was quite satisfactory except for the matter of ratings and rank." *****

***** "In Air Force units the medical personnel see ever changing groups of flying personnel constantly coming and going and rising in rank with a rapid speed. The medical people, who are under-ranked to begin


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT HISTORICAL RECORDS OF WORLD WAR II. (1st Bombardment Division 44) Continued

with, soon have removed that incentive to combined effort which aspiration to higher rank supplies. This fact coupled with the absence from definitive medical activity, continued long absence from home, and the placing of too much stock in unfounded optimistic rumors all are responsible for the lowered morale and efficiency. To combat this lowered morale and efficiency and to improve the character of the medical service to the Army, the following suggestions are offered.

"First --- That medical and dental officers on duty overseas be rotated back to the zone of the interior after one and a half years overseas duty and be given a hospital assignment in their preferred specialty for a period of six months and at the end of that period they be reassigned to a position similar to the one they have occupied, overseas again, if in keeping with the strategy of the Air Forces.


"Second -- That the T/O rank for Medical and Dental officers be increased in the tactical units to correspond more closely with the dignity and responsibilities of their staff duties.

"Third -- That authoritative information on the planning for rotation and professional opportunities be disseminated more fluidly to the medical personnel in order to offset any unfounded rumors." *****

***** "If an officer, after two years of Army service in the rank of captain, is not worthy of promotion, then it would seem that he is not even worthy of the lower rank, and should be reduced in rank or discharged for the convenience and better functioning of the Army. If an officer is deemed worthy and deserving of promotion, then it might be considered whether the Army would not profit by allowing the promotion, and thus encouraging said officer to further effort in the conscientious execution of his duties. Delegation of responsibilities and duties commensurate with an officer's capabilities might also be expected to stimulate in him an efficiency engendered by pride in his work. It is conceivable that rigid adherence to a Table of Organization, for officers and enlisted men, may not always work to the best interests of the Army."

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT HISTORICAL RECORDS OF WORLD WAR II. (Ltr. 31 July 1943 from Col. M.C. Grow, Surgeon 8th AF, to Brig. Gen. Grant TAS)

***** "In the past our groups and wings have most always arrived in the U.K. with the medical officers promoted to the grade called for on the T/O. When that is the case it gives us little or no change to make re -


L. K. Pohl, Colonel, MC

RESTRICTED

(r)

RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT HISTORICAL RECORDS OF WORLD WAR II. (Ltr. 31 July 1943 from Col. W.C. Grow, Surgeon 8th AF, to Brig. Gen. Grant TAS) - Continued -

assignment within the Air Force which may be indicated. ***** I Fully realize that it is the prerogative of the commanding officer to promote his officers but anything you can do to discourage the practice of promoting medical officers as high as possible before going overseas would be a great help. Many of the officers appear to be under the impression that promotions are haphazardly made overseas with regard of Table of Organization vacancies and as you know that is not the case. As soon as they find that they are promoted to the top of the ladder in their unit they tend to become disgruntled and apply for reassignment, but there is no place to put them which calls for a higher grade. Consequently their morale suffers quite a blow." *****


(Memo, 22 March 1944 from Surgeon, Air Service Command, USSTAF to Gen. Grant)

***** "1. The allotment of grades for medical department enlisted men in combat units is too low; morale among deserving enlisted men in this category would be greatly improved by boosting the allotted grades both in headquarters and squadron medical sections.

"2. In consideration of the responsibilities and usual professional activities of group and squadron flight surgeons as compared to the responsibilities, training, and activities of their line officer colleagues, it seems definitely indicated that grades for group and squadron flight surgeons should be elevated." *****

(Ltr. to: Whomever it may concern dtd 6 Feb. 1943 Unsigned (submitted by Col. Robinson, but probably prepared by Maj. Rergerman)

"The provision made in the original T/O, Allotments and Grades for Medical Enlisted Men, were grossly inadequate for the men who are now filling the various positions and responsibilities that have been placed on them. This has resulted in unrest and discontentment amongst the medical soldiers since they have no possibility for advancement. Therefore, it is felt that their reason is entirely justified and that some correction should be made."*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT HISTORICAL RECORDS OF WORLD WAR II. (31 Ftr. Grp.)


***** "... medical personnel have not been able to rise beyond the grade of corporal or sergeant because of T/O limitations while their associates with whom they live and eat and who are Air Corps troops have frequently risen from Pvt. to T/Sgt. or M/Sgt. in the same length of time. It is felt that the promotion policy for Air Corps troops if continued should be extended to cover such assigned personnel as Ordnance and Medical Department troops rather than have them under a separate and relatively limited T/O. It is likewise felt that there should be some flexibility in T/O; e.g. instead of a T/O calling for six privates it should call for six privates or privates first class.***** Suggests rotation of MC officers between field and hospital duty of perhaps six months." *****

(1st Av. Sq. - MTO - Personnel)

***** "It is felt that the grades of the medical personnel as set forth in the T/O are inadequate. This discrepancy is all the more noticeable when compared with the grades in the other sections or departments of the Squadron. The medical personnel in this squadron are well trained and specialized in their work as much so as an airplane inspector, welder, etc., and grades should be commensurate with their skills."*****

(IASAC), 1-17 - MTO: Medical Supply)

"At Casablanca, a similar problem was developing with regard to air force casualties as had been experienced at La Senia. In order to give the personnel medical care, medical personnel were made available upon recommendation of the Medical Section through the 37 Air Depot Group. By March 1943 the problem that was to dog the Medical Section, throughout its existence, had presented itself. This was the problem of distance, of many miles and the many hours between air fields and hospitals and hospitals and medical supply depots. The first two fields to present the problem were the ones at Marrakech, and the other at Ras El Ma, just west of Fez, both places were about 150 miles from Casablanca and therefore that distance from hospitals and supplies. To meet the situation at these fields as they developed, it was frequently necessary to act first, and later to obtain authority for what was done. Cots, blankets, microscopes, bed pans and other essential paraphernalia were issued on the order of the medical section by the 2nd Medical Supply Platoon. The same principle of action obtained for ambulances. It was possible, therefore, to give good quarters treatment locally at isolated fields, to evacuate promptly, and yet to have the landing strips adequately covered at all times."*****


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY (Ltr Dr. H.S. Hoffman, dtd 13 May 48)

***** F. "Within the Continental Limits: Personnel: Good
Equipment: Excellent
Training: Adequate
(Mission &
(Tactical Requirements: Adequately met.

Outside the Continental Limits: Ashore: Moderate to large organizations
Personnel: Good
Equipment: Excellent
Training: Good
(Mission &
(Tactical Requirements: Adequately met.

Smaller Organizations: Personnel: Frequently inadequate from the point of
view of selection, but adequate in number.
Equipment: Excellent
Training: Definitely inadequate early in war, but a
marked improvement was effected later.
Mission &
Tactical Requirements: Adequately met, frequently
under difficult conditions.

Afloat - Hospital Ships: Excellent

Outstanding Deficiencies Noted: 1) Personnel, training and special equipment for Sanitation and Public Health in captured Pacific Islands; It was not until 1944 that these activities rose to approximately adequate levels in the planning and preparation phase. However, execution of plans frequently lagged appreciably because of the failure of the Line to cooperate. In this matter Commanding Officers (Line) were almost wholly responsible. In one campaign the occupation forces lost approximately 80,000 man days from Dengue and Dysentery in the first month ashore. Later, when the Occupation Commander was informed of this figure, plus the fact that conservatively 75% of this loss could have been prevented if he had approved the recommendations of his medical department during the staging period, and after arrival on the target had he not prevented his medical staff officers from functioning in the first two weeks, he merely shrugged his shoulders. 2) Assignment of medical officers for Civil Affairs early in the occupation phase of Pacific Islands was inadequate. In one island, with a known pre-war native population (American Nationals) of between 22,000 and 25,000, only two medical officers were assigned, despite the protest of the staff medical officer. *****

RECORDED

RESTRICTED

RESTRICTED

**TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS
HISTORICAL SECTION - AFPS**

***** F. "Three general problems of organization and administration confronted the Eighth Air Force during the immediate months following the arrival of the first units in England. They involved issues concerning the supervision of the echelon medical service; the establishment of medical policies and projects relating to evacuation, hospitalization, and supplies; the failure to provide casual medical personnel for assignment by the surgeon to units that were without Tables of Organization; and, finally, the difficulties associated with the assignment of key Medical Department officers to Medical Section, Headquarters, Eighth Air Force, and the four Air Force Command Headquarters for duty as special staff officers.

The lack of sufficient experienced personnel for the organization of the medical services of the Eighth Air Force was due to the failure to provide early in the war an ample number of qualified medical officers for any other than the major key positions and the policy, made necessary by the projected size of the Air Forces, of delegating detailed control of medical matters, in so far as possible, to the various command surgeons' offices. The major positions at this level demanded the highest type of trained and experienced personnel and as appointments were made to fill them the experience level gradually declined. Eventually, it became necessary to train capable officers in the theater in order not to prolong a delay in the functioning of the surgeons' offices in the commands.

From an administrative standpoint another personnel problem of "considerable concern" developed. Before leaving the US, the Surgeon of the Eighth Air Force made a study of the units involved in the Balore Plan which forecast the sending of 230,000 troops to the European Theater over a 10 month period. It revealed that of this number approximately 50,000 service troops would eventually be sent overseas without attached medical, veterinary, or dental personnel.

The plan proposing a Veterinary Platoon, Aviation, received favorable consideration. It provided a headquarters and one detachment consisting of one veterinary officer and two or three enlisted men of the Medical Department (Veterinary Service) for any air force consisting of 25,000 troops or more. One detachment would be added for each additional 25,000 troops. The chief administrative officer of the organization, the platoon commander (later designated as Eighth Air Force Veterinarian) was given command and staff responsibilities. In the latter capacity he would have supervision of the Air Force veterinary service and serve as an assistant to the surgeon.

The detachment commander would be responsible to the platoon commander for the technical administration, training and operation of the detachment. As attending veterinarian in the area, he would be required to inspect the feed and all sources of such feed of animal origin issued by the units under his supervision.

The Platoon Aviation Detachments, according to the plan, would function on an area basis, their personnel being attached to some centrally located station for rations, quarters, and supplies. From this point they would render veterinary service to all stations and airdromes within the area regardless of whether they were occupied by bomber, fighter, or other command units.

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS, CONTINUED

The dental officer personnel ratio stood at 1:1300 on the first day of January 1944. This "gross inadequacy" of Dental Corps officers was partially corrected by the establishment of a Dental Detachment at Large, but the ratio of total personnel strength to dental officers strength was still too high on 31 December 1944 to permit the degree of dental strength of service desired by the Eighth Air Force.

The morale of the Dental Detachment at Large was somewhat low. The personnel was on detached service and attached to the various service and tactical groups for rations, quarters and duty. Often they were not considered as being members of a permanent organization. Since no provisions were authorized for the administration of the Detachment, it was a constant source of annoyance to the Machine Records Units, to station surgeons, and all administrative channels with which its personnel came in contact.

The circumstances responsible for shortages of medical and dental personnel during the first half of the war period were of early origin. The scattered evidence, though at times somewhat confusing, indicates improper utilization in several instances of the medical force in the theater itself, the existence of questionable policies, and a lack of trained personnel.

The allotment of medical officers and enlisted men in the Air Forces was governed primarily by three basic considerations. In the first place, The Adjutant General decided in February 1942 that the Army Air Forces would be responsible only for the medical service within the Army Air Force unit in the theater of operations. Secondly, the supply of medical personnel for the armed forces was limited; and, finally, the medical needs of an Air Force unit were not commensurate to that of the Ground Forces. The latter, it was pointed out, usually engages at least two-thirds of its personnel in close combat for prolonged periods. Consequently, the casualty rate is high, frequently amounting to 15 percent or more in a period of twenty-four hours. The assignment, therefore, of a large proportion of the medical personnel and equipment to them was regarded as necessary. On the other hand, the Air Force units fight enemy piecemeal for short periods and seldom engage more than 10 percent of their personnel. The casualty rate is correspondingly low. In the Far East it was less than 1 percent of the total strength in a period of twenty-four hours except when the units were caught without preparation and warning. Therefore, the Commanding General of the Army Air Forces directed that a minimum out of 35 percent be made in the medical personnel and equipment for all arms and services with the Army Air Forces.

The Office of the Air Surgeon in pursuance of the order reduced all tactical group headquarters and headquarters squadrons from sixteen enlisted men to three, eliminated group headquarters aid station equipment, and disbanded all medical detachments assigned to the air depot group for the purpose of operating a dispensary.

The execution of the reduction in force order explains, in part, by the request of the Eighth Air Force, in June 1942, to increase the number of its medical officers from 479 to 733 and its dental officers from 146 to 293, and to provide one veterinary officer and one veterinary assistant for each of the 70 airdromes scheduled to accommodate approximately 3,000 troops, was turned down by those preparing the Bolero Plan for England and regarded as being "diametric-

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS, CONTINUED

ally opposed to War Department policy".

An effort was put forth to justify on other grounds the denial of additional medical personnel to the Eighth Air Force. It was suggested that the reduction of medical personnel and equipment, as authorized by the revised Tables of Organization and Tables of Basic Allowances, would not impair the medical service because operations in Belero would most likely be of a more stabilized nature than those in the Far East and Australia. Here, the medical sections, as staffed, were functioning satisfactorily. Dental Officers, it was explained, had never been procurable at the ratio of 1 to every 750 men. Furthermore, the need for them in this proportion would not exist in combat zones where dental service should be restricted to emergency treatments. The reception and replacement Centers were the proper places for complete dental care.

The unavailability of medical personnel furnished by the Manpower Commission during 1942-43 was the "basic barrier" in providing the Air Forces with suitable medical personnel. On 23 February 1943, Gen. D.H.W. Grant, The Air Surgeon, wrote Col. M.G. Grow, Surgeon, Eighth Air Force, that "Because of shortage of medical personnel available to the armed forces, we were required to cut out requirements (as of December 1943) by approximately 5,000 medical officers. With our rate of expansion, in the future I can see a shortage of medical personnel almost as bad as when you were in the GHQ Air Force.

The point has been reached "where an increase in one place had to be balanced by a decrease somewhere else".

The suggestions and proposals advanced to alleviate the shortage of medical personnel in the theater involved the training of personnel, the providing of casuals, mobile dispensaries, and flexible Tables of Organization. Their primary purpose was not only to increase the numbers of qualified medical officers but to introduce an element of elasticity in the medical organization of the Eighth Air Force in order to effect a better utilization of the existing supply of trained personnel. Some were approved, others rejected and subsequently approved, and a number definitely disapproved by higher authority.

Two proposals were made by the Surgeon, Eighth Air Force, to alleviate the situation of these isolated groups in the theater without medical services. His efforts to secure a casual pool from which to draw medical officers for appointment to these isolated groups were continually turned down, as stated earlier, by higher authority on the ground that they were "so grouped as to receive medical attention from other Army Air Force units. On the other hand, his suggestion that small mobile dispensaries on the basis of 1 to each 5,000 troops be provided to render them medical service resulted in the formation of the Medical Dispensary Detachment, Aviation, for use in the theaters of operation. Even though the units were partially motorized, their personnel and materials were of such a nature as to permit easy transportation by air.

The need for a more flexible Manning Table which would allow the use of discretion on the part of the surgeon in distributing his personnel was continuously urged and supported by facts. "*****"

RECORDER

RESTRICTED

W. L. FOML, Colonel, MC

373

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT FROM AIR EVALUATION BOARD SWPA REPORT NO. 35. THE MEDICAL SUPPORT OF AIR WARFARE IN THE SOUTH AND SWPA FROM DECEMBER 7, 1941 to AUGUST 1945.

***** F. The organization of the medical services of the Fifth, Thirteenth and Far East Air Forces followed the general pattern laid down in War Department and AAF regulations and T/O's. However, the rigid organization imposed by these directives did not permit the assignment of medical officers according to the requirements which existed in these theaters. Certain units were overstaffed with Medical Officers while others were markedly understaffed. A unit operating as an entirety in one area required fewer medical officers than when individual sections of the unit were established in widely separated areas. In addition, there was no position authorized in T/O's for certain personnel whose assignment to the Air Forces was absolutely necessary in order to fulfill the mission of the Medical Department in these theaters. There was no pool of medical officers from which personnel could be drawn in case position vacancies occurred due to sickness, death or other emergencies. It was believed that such a pool would have made possible the rotation of Air Force Medical Officers into hospitals where they could refresh their medical training. Personnel in the pool, therefore, would have been employed at all times.

A similar deficiency in Dental Officers occurred in these theaters. As a result the dental health of Air Force troops became progressively poorer. The number of Dental and Medical Officers required to perform the necessary duties efficiently was greater than the number authorized in existing T/O's. *****

L. K. POHL
L. K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Extract of statements made by Colonel Thomas J. Hartford, MC, USA on 23 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

***** "f. I felt that the units were not too bad, and if I had the job tomorrow of creating new units, I wouldn't need very many that we don't have. I think the ones we have perhaps can be improved on. I don't think we have the answer yet to a holding unit; in other words, the installation that holds the people on the air fields. And I think that we ought to have some type unit that assembles and makes some use of captured enemy equipment rather than be tossed around the battlefield like it was in this war; but aside from that, I don't have many recommendations on units, unless someone has something they want to bring up.

I don't think you would ever have enough personnel and installations without wastage to take care of certain peak periods, and that you will always have surgical backlogs even when you are very well off in personnel.

I would like to comment briefly on this question, "Were medical units adequately trained on their arrival overseas?" I think our medical department replacement training was good because I saw that training; but there are certain things that you can get experience and training only when you are pretty close to that final line over which you start fighting each other, and it was common--I think we are all guilty of saying that everybody we got we had to train all over again, and so forth. That wasn't quite true. We weren't very generous in that respect. I think we should keep in mind that there is certain training that we must be gotten a little closer to the battle front than in our training centers.

Communication between medical units was not satisfactory. We wasted personnel because we had no other means of communicating it. It meant the establishment of many ambulance relay posts and other installations for which no T/O was provided in order to make the thing work at all. So I think we ought to write in to our medical T/O's and bring it to the staff's attention that we must have communication and probably in the future conflict it will be even more necessary than it is now; probably should parallel the unit that is being supported. I still think we need a little control.

Presence of females in medical field units is definitely worthwhile, and they are necessary as much for psychological reasons as they are for professional reasons. I think if anybody was paid

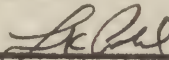
RESTRICTED

RESTRICTED

CONFIDENTIAL

***** "f. a tribute it ought to be the nurses in field hospitals insofar as the Army is concerned.

I didn't have any experience in moving females. I don't know whether they hampered the movement of units, or not. I couldn't say. I think they probably do somewhat, but by and large it's to be remembered they are all volunteers and they didn't give us too much trouble. *****



L. K. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRAC COPY (Ltr Lt. Col Walter J. Reuter, Dental Corps, dtd 11 May 48)

***** F. "Authorization of Dental Officers. g. Deficiency - The number of dental officers provided by Tables of Organization was deficient by approximately 50%. In 1944, Tables of Organization for the Fifth Air Force provided dentists at the ratio of 1 - 1941. In the 13th Air Force, Table of Organization provided dentists at a ratio of approximately 1 - 2000. In November 1944, the Fifth Air Force had twenty organizations each having a strength of less than 200 men, five organizations with a strength of less than 200, three organizations with a strength of less than 400, one organization with a strength of less than 500, and one organization with a strength of less than 800, none of which had a dental officer authorized. They comprised 32% of the total strength of the Air Force. The situation was similar in other Air Forces. In the Far Eastern Air Force, Tables of Organization early in 1945 provided dentists at a ratio of 1 - 1909. In June 1945 this authorization was augmented by 62 officers by the activation of 62 dental operating detachments. In the Eighth Air Force, in 1944, dental officers were provided by Tables of Organization at the ratio of approximately 1 - 2050. This was augmented by the activation of the Eighth Air Force Dental Detachment (At Large) in November 1943, providing for 108 additional officers and establishing a new ratio of approximately 1 - 950. This inadequate provision of dental officers by Tables of Organization existed in all Air Forces. In some Air Forces it was compensated for by the authorization of dental detachments. In some Air Forces this was achieved as hostilities ceased. h. Unfavorable Effects - Those Air Forces in which an additional authorization of dental officers above the regular T/O allowance was not obtained, or in which it was obtained late in the war, were very much understaffed. Dental officers were grossly overworked and were able to meet only the most urgent requirements. Many small units and detachments in isolated areas were without dental service for extended periods of time and larger units were understaffed. There is no doubt that many a tooth has been lost because the necessary attention was not available at the time it was needed. Embarrassment no doubt was avoided by the good fortune that there was not an outbreak of a serious epidemic such as Vincent's Stomatitis.

g. Recommendations - Authorization of dental personnel by one of the following methods, of which the first is much preferred:

1) In addition to the staff dental officers at the various Air Force and command headquarters, provide a blanket authorization of dental officers at a ratio of 1 - 1000 (or other predetermined ratio), the actual dental officer requirement thereby being determined by the strength of the Air Force; dental officers to be assigned not to units as groups and the like, but to dental detachments of various sizes with approved Tables of Organization; dental detachments to be activated and deactivated according to the fluctuation of the Air Force strength; all dental personnel to be under the immediate control of the staff dental officer of the command; dental enlisted personnel to be authorized and assigned on the same basis. This plan was employed in the Third Division in France during the war with great success.

2) In addition to the staff dental officers at the various Air Force and command headquarters, a limited number be provided for in Tables of Organization of tactical units and the remainder authorized in such numbers as will establish the desired officer personnel ratio; these additional officers to be assigned and under the control of the staff dental officer as in 1) above; en-

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY (Ltr LtCol Walter J. Reuter, Dental Corps, dtd 11 May 48, **CONF.**)

listed personnel to be provided in the same manner. This plan was utilized successfully in the Eighth Air Force, with the exception that officers assigned to the dental detachment and on detached service with a unit knew and felt that they did not have the privileges the unit dental surgeon had and therefore felt they were being discriminated against. This was a minor yet a definite personnel problem.*****


Lt Col
L. E. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral G. B. Cameron (MC), U.S.N.,
Retired dated 21 April 1948)

*** "All acceptable Medical personnel should be carefully and thoroughly screened PHYSICALLY, PROFESSIONALLY and RACIALLY and only assigned accordingly, following the standard course of indoctrination. In brief, 'the right man for the right job' insofar as experience and exigencies dictate. Much can be accomplished and gained by the adoption of such an over-all policy." ***


L. K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr James E. Hix, Lt Col., MC (Resigned) 11 April 1948)

****The tactical organization will have to change with the change by the tactical boys. I visualize the next as almost entirely air until occupation time arrives. Get you a good air transportable unit--keeping it small and plan air evac to the specialist centers in the zone of the interior. Use only that portion of logistics which reflect on experience by air, toss the rest by the board. True your'e gambling, but in the next one--you better be right. There probably won't be time for many changes.****

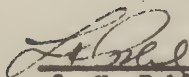
RESTRICTED
L. E. Fohl
L. E. Fohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Robert E. Peyton, MC, USA
dated 19 April 1948)

***** This is certain: Within a theater of operations the chief surgeon must serve his commander. He cannot serve two masters -- that sort of thing has never been possible and never will be. Failure is inevitable if it is assumed that the desires of a chief surgeon are to be paramount to all other considerations of the theater commander. The medical service cannot do just what it pleases and when it pleases with complete disregard to what the theater commander determines to be necessary to win victory in battle. *****



L. K. Pohl, Colonel, MC


RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Rear Admiral A. M. Dearing (MC), USN
dated 26 April 1948)

**** "(f) Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirement.

The original Naval mobile hospitals were excellently equipped, had well trained and sufficient personnel. They were, however, too immobile for rapid movement within the field. However, if provided in sufficient number to allow for a period of at least six months during which the hospital buildings may be broken down, shipped and set up in another area, they provide an excellent base hospital for extra continental use. There was considerable criticism of these hospitals in the South Pacific as being too luxurious as compared to Army evacuation hospitals which were of about the same size and were supposed to be placed under canvas. I believe that housing of the type utilized by our mobile (Fleet) hospitals is excellent and that its use should be continued for the erection of base hospitals. The utilization of the 6 components for hospitals in the more advanced areas is probably preferable. ****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic A. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

***** "My answer to (F) 1 is naturally limited to personal observation. Almost every unit I had occasion to use was designed for something else and had to be remodeled. That does not, in my opinion, reflect any error on the part of the over-all planning. I think that my field hospitals were perfectly good field hospitals. As far as I know the units and organizations set up by the surgeon general's office were, let me say, reasonably sufficient in personnel to do the job that the people in the surgeon general's office thought they were going to do. The fact that in I guess every theater some at least were used in other jobs and caused necessitated rebuilding I don't think should reflect on basic planning. I have no recommendations or reference to any particular unit that I think was inadequately staffed or had inadequate facilities. These observations were for the most part based on peak loads and emergencies, and every unit that I had contact with during combat was overloaded I suppose as much as every other unit, and every other theater was overloaded during combat. I will say that I think the medical units and medical personnel showed an almost impossible-to-understand ability to overload.

"(F) 2. The latest units to come to my attention overseas—by that I mean the ones that left the states the latest—showed evidence of least amount of training, and I think this was probably due to going stale, losing enthusiasm and loss of personnel at the wrong time. I don't think that reflects anything other than the war was coming to an end and they were getting to the bottom of the barrel and were making units hurriedly and not giving them the amount of properly-balanced training that they had been getting during the major portions of the war.

"Wastage of doctors comes into this picture very definitely and I have already covered that in previous statements.

"(F) 3. I have only one suggestion on glaring deficiencies in the equipment of medical units that I noticed in every single medical unit, and that was in lighting equipment and adequacy of generator systems furnished. Various units had their own deficiencies, but this I would say was universal in every medical unit I saw.

"(F) 4. If units are restricted to table of organization equipment, I think it would be far better to stock advance bases for this equipment and let the unit pick it up. If units are going to be permitted, as they were in some theaters and under some conditions, to personalize their equipment—and I think it's fine when they can do it—then I think it's much better from the morale standpoint to take their own equipment along with them."

RECORDER
L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTEDEXTRACT OF STATEMENTS MADE BYColonel Frederic B. Westervelt, MC, U. S. A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

"Most units, if permitted, get heavier by the minute. They pick up everything they can to make themselves comfortable and happy, and as long as that doesn't interfere with the logistics' effort of the command, I am heartily in favor of it.

"(F) 5. I can't think of any specific new units. I have given this a lot of thought. I have talked it over with other people. As you know, there are modifications being made in sizes of units, in certain specific functions of units; I can't think of any particularly new unit that should be added.

"(F) 6. The planning figures for a specific task was done by specific headquarters. As far as I am concerned, the medical headquarters or the medical agency in the headquarters planning any task in which I had any connection whatsoever planned adequate medical support. That medical support was not available, therefore, I assume that that reflects planning at the top level for the over-all tasks. I assume that there was a breakdown or an inadequate amount of planning or inadequate result of planning at the highest level due to, I am sure, perfectly understandable factors which I have no knowledge of.*****"

RECORDER

L. K. Pohl

 L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL NORTON H. WILLCUTTS (NO) USN
4 May 1948.

***** F. "In both your experience at San Diego and in the Pacific, what was your estimate of the efficiency of the different medical department units as far as these various component features were concerned for the job necessary to do? Do you have any suggestions about modifications?

REAR ADMIRAL WILLCUTTS: My reaction of the San Diego Hospital - and I speak again of my hospital - was that we ran a hospital that was efficient because we had such a large patient load. Naturally the bigger the load the more the per person load will be cut down. We ran a hospital that cost as low as \$1.18. I am not sure of that figure, but it was the lowest for hospitals. What? Why? Because the bigger the formula, the less it cost. So I think the hospitals on the West Coast were most efficiently run. Certainly some of the convalescent hospitals were expensive. But these poor devils rated everything. They went up to these beautiful hotels and camps that were provided them for convalescence; and I think it probably was money well spent.*****

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL CORNELL, MG, USA, 30 April 1948.

***** F. "Basically I believe there should be more elasticity as to number and rank. Static T/O's do not vary with circumstances enough. I know they are necessary for allotment of manpower, but I believe that within a theater ability to deviate from that T/O occasionally should be permitted.

Greater use of limited-service personnel in non-tactical medical units; that is, not in the front line, but in rear units. But that use must start at home in the period of organization and training, not overseas in a working outfit. We could have used 75 percent limited service personnel. The number varied from 22 to 28 per cent. The difference we could well have spared as good husky men, but naturally any commanding office is going to resent having his unit broken up after he has spent a year or more training technicians, and they had to be protected; yet we would have welcomed limited-service personnel when we were training the men to begin with.

Continuity of the unit in personnel is a great morale factor and the earlier a group can be welded the better they function. Training of units with all officers and enlisted men present is most important. Some of our officers did not join until later. They never were through the training period with a group. I think any unit that can be should be welded together in the training period.

BRIGADIER GENERAL MARTIN: Should we increase the female component in our field and fixed units, particularly in the field of medicine?

COLONEL CORNELL: I would have been very glad to have had about one-third of my unit female technicians. In fact, in 1936 and 7 when I broke down the T/O for the first general laboratory while I was up in NY, I checkmarked certain squares for the individuals and it worked out to be just about 33 or 35 percent, and I made a little note on the form that these may be female technicians.

RESTRICTED

RESTRICTED

THIS COPY EXTRACT OF INTERVIEW WITH COLONEL CORNELL, NC, USA.

2. CONTINUED:

I would like to say this: I would have been very glad to have had them sent to work each day in my laboratory and returned to their WAC barracks at night, so that their control, living conditions and everything, were apart from the unit. I thought that could have been worked particularly in our medical center, I think girls could have been used in all of those units. We needed stenographers and typists. I had none. There were girls that could have done it very well and there were girls who undoubtedly could have done a lot of other technical work in all of our laboratories.

Of course, we are going to strip the laboratories of female technicians in civilian life and we would be stripping them if we took them in wartime from these hospitals which are in need of them now. We did that in World War I. We stole technicians from NY State, City Board of Health, and all around the port of embarkation. We sent them around and found that some of them did not stand exposure to the distant points as well. I think one reason was that we were sending one or two girls to a post to work in a laboratory. They were not nurses nor did they live in nurses' quarters. They were on their own. They couldn't stand the strain for one reason or another. Whereas when we sent them out as a unit, as we did in this war, the WAC unit, they had the control that I think is necessary and had the companionship of course which is also necessary and proper supervision. I think they have a place, yes, but I think we should train some of them during peacetime and not strip the civilian institutions at the outbreak of hostilities.*****

RECORDED

L.K. FOML

L.K. FOML, COLONEL, NC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH BRIG. GEN. JOSEPH E. BASTION, MC, USA (RETIRED)
3 May 1948

***** F. "Medical Department organizations from the standpoint of personnel, equipment, training, and mission or tactical requirement.

Off the record.

BRIGADIER GENERAL BASTION: Hospitalization and evacuation policies within the combat zone and evacuation to the communication zone and to the zone of the interior. Well, of course, I saw the stuff coming back, and I only got hearsay evidence that the thing seemed to work. I talked to patients and officers coming back. As far as I know - this is just my own opinion - I can see no reason for any change right now."*****


G.K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA,
13 May 1948)

**** MAJOR GENERAL KENNER: "Getting down to the next question of Medical Department organization, and so forth, which is the next question, there is too much of that to be gone into in detail. However, I think there are two essentials in any medical department organization, having in mind a type of warfare that may be somewhat different from that which we had in the last two wars. I think mobility and flexibility must be stressed, that equipment must be limited to that considered indispensable for field units and reduced in weight by using the lighter metals, because a lot of our medical units and equipment will have to be air borne if we are visualizing the kind of war that I think we will be confronted with.

We did have some of that, as you recall, in this past war. We had these air field units we could move in, in one C-47, with the personnel and set down on a forward strip. But assuming that we are able to carry the war to the other fellow, that presupposes bases within a certain radius. It also resupposes, in order to get into the other fellows territory, we will have to be air borne, because the ports will not be available to us. They will probably have been blown up either by ourselves or by the enemy. We are also assuming that before we can invade we will have quite a bit of destruction on enemy installations and cities and that, therefore, the only way to get troops into a combat area on enemy territory would be to get them in by air.

Certainly everything counts. We must strip down to bear essentials for all medical tactical units with proper air available to us for medical purposes. We must depend upon rapid evacuations to properly staffed and equipped major medical installations somewhere in the rear, either bases or back to this country. *****

***** BRIGADIER GENERAL MARTIN: There has been discussion about the number of physicians who will be available to the medical service in case of another national emergency. Do you think that our medical units overseas during the last war were overstaffed?

MAJOR GENERAL KENNER: Yes, I do. I think that in your base installations, in many instances, they were overstaffed, overstaffed in the sense that their patient load was such as to not require the staff available at any particular time. I believe, too, that our field units on occasion were overstaffed. I believe that this was principally the fault of higher headquarters, partly because of our methods of handling medical units. For instance, in an Army unit you have surgeon divisions committed. That division may suffer severe casualties. And then we may have another division in support suffering very minor casualties. And we may have a third division in reserve suffering no

RESTRICTED

RESTRICTED

casualties. At one time all of them have the same complement, officers and enlisted men.

I believe that an Army Surgeon should be authorized to take such action as he deems necessary in the handling of all personnel within that Army without reference to the Army Commander's G-4 -- that he should be authorized to meet a given situation as he sees fit.

We know right off what he will run into there. This division commander is going to raise hell if the doctor comes along and wants to pull out some of his doctors and use them someplace else. But I think that Army Surgeon, rather than having to go through G-4 and make a presentation of the situation and of his requirements and get a decision from G-4, should represent the Army Commander and make his decision in the field to meet whatever emergency may arise.

I think one complaint of overstaffing was that here was a hospital sitting back off here with a half dozen patients, whereas several other hospitals up front were being worked to death. Those things are more administrative matters than actual overstaffing.

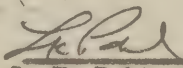
We consider the reason we set up a certain T/O&M was because we would have a self-contained, balanced unit, capable of properly performing its function. Whether it is actually performing those functions at any one time is something else. It seems to me to be a matter of making the most of what you have.

BRIGADIER GENERAL MARTIN: Would you extend that concept to the shifting of medical and other branch equipment for the same purposes, without reference to G-4 limitations -- blanket restrictions on tables of allowances?

MAJOR GENERAL KENNER: It is my opinion, again, that the surgeon responsible within his own sphere should be authorized by his commander to take whatever action he deems necessary to carry out his mission and his responsibility for the medical support of the troops of that unit. Fortunately, with George Patton, I had that authority. I could go into a unit and take out doctors and equipment, or anything else I needed to meet any situation. I apologized to the line commander when I did it, but I did it just the same because I was supported by my chief. I think that should apply generally and be a recognized concept of the medical service. If an Army Surgeon with responsibility to his commander is denied the authority to take definitive action in any emergency, then he is not needed at that level. cccc

cccc Going on with this question (f), base and XI supporting installations should be fully equipped to render definitive care." cccc

RESTRICTED


L. E. Pohl, Colonel, MC

369

RESTRICTED

Extracts of Statements made by Brig Gen Robert C. McDonald, MC, USA (Retired),
21 April 1948, before the Subcommittee on the Employment of Military Medical
Resources.

****"Medical organizations were generally overstaffed at the beginning of World
War II."

I think in the general hospital of a thousand beds we had something like 43
medical officers, plus a large number of medical administrative officers and
dental officers and others; making a total of perhaps over 60. We found out
later that wasn't necessary, that perhaps half of that number of medical officers
could do the essential professional work, turning over to nonmedical personnel
as much of the administrative and routine work of operating a hospital as was
practicable.

"The specially qualified personnel available had to be spread thin enough
to man all organizations" in the later stages of the war. "Medical equipment
was adequate in most organizations. The development of special equipment for
jungle warfare was outstanding. The development in peacetime of special equip-
ment needed in Arctic climates is most valuable and timely. The training of Medical
Department Personnel was well organized, and generally well done. The tactical
employment of Medical Organizations was well planned and carried out," as far as
I know. I did not serve in a combat zone.

The handling of the sick and wounded brought back from Europe in the later
stages of the war was well handled. In the Fourth Service Command we brought most
of the badly wounded and seriously ill patients—that is, litter patients—in to
Charleston, and from there in the hospital trains operated by the Office of the
Surgeon General they were very expeditiously distributed to various hospitals.

There did develop a great difficulty because of the distribution of our
general hospitals; namely, badly wounded patients who were later to be discharged
from the service could not be hospitalized near their homes.

There was a policy early in the war, when we were afraid the Germans, or somebody
would be bombing over here, established by the War Department of not building
general hospitals close to the Coast.

I was Surgeon of the Third Service Command over here at Baltimore in 1942,
and I found I was terribly crippled by that. We had lots of population, but very
few general hospitals. I made strong recommendations that they abandon that policy
and build hospitals along the Coast where they were needed the most, and they did
do that in my own Service Command. They established one out here in the
Shenandoah Valley and in Richmond and at Philadelphia and Pittsburgh. We did
finally get a chain of hospitals.

I don't believe that we can base our distribution of hospitals on any such
basis as that. It may readily be seen that they perhaps should not be in the
middle of great centers of population, but certainly they shouldn't consider the Coast
as so vulnerable that we can't put any hospitals anywhere near it.

RESTRICTED

RESTRICTED

The medical units for the communications zone, particularly for the combat zone, should have supplies and equipment to enable them to carry on for a reasonable period. That depends, of course, upon the location of the theater, upon the nature of the warfare, upon the strength of the enemy, and various other factors; but certainly as a general rule I think something like 30 days of expendable supplies for a combat unit would be reasonable in going into the theater, and another 30 days, perhaps in the Army area, and then into communications anywhere from 60 days to four months or even six months, depending upon the security of the line of communications and the combat situation.

"In general, did medical department units and organizations have sufficient personnel? If not, how was the deficiency corrected by you? Have you any specific recommendations for particularly inadequately staffed units or facilities? Were your observations based on peak loads or emergencies or on so-called normal loads?"

It applied to my units down there. I had a great shortage of personnel, enlisted personnel in general hospitals, in large station hospitals. It was met by assigning prisoners of war on duty; and they did splendid work. In fact, we couldn't have gotten along through the early stages of the demobilization without them, because we did not have enough personnel to carry on.

"Do we need any new medical units? If so, for what specifically? What is the basis of your recommendation?"

I can't comment on that. We may need units, but I don't know just what they are and what they should do. We certainly are developing new ways of warfare, and it is probably going to call for new types of units. But I don't know what they are.

"Did our planning figures allow for enough medical department units in any given task? Should we revise our planning data for medical cases in forward areas? Atomic warfare?"

I didn't have knowledge of that situation. I think, generally speaking, that when we organized a task force or tried to set up equipment for a war plan, that enough stuff was sent over there probably to cover it. But in its distribution over there, I don't know what the situation was, or what the situation was after the expansion. My comments wouldn't be worthwhile.

"Did the presence of females in medical field units prove worthwhile? Necessary for professional reasons? For psychological reasons? Should we increase the female component in our field and fixed units wherever possible? Did females hamper the movement of units? Did they reduce the mobility of units because of their necessary separate accommodations?"

I don't know about that.

Brig Gen Martin: I'd like you to answer the last part.

Brig Gen McDonald: The Wacs did excellent service in my service command.

Brig Gen Martin: The question is -- should we increase the use of females?

Brig Gen McDonald: Not in the combat zone.

RESTRICTED

RESTRICTED

Brig Gen Martin: You have had experience in a fixed zone.

Brig Gen McDonald: Yes, we can use more females.*****

L. E. Pohl
L. E. POHL
Colonel, MC

RESTRICTED

RESTRICTED

D-1g. Medical logistics in military campaigns.

I. DISCUSSION

1. The shortages of numerous items of medical equipment and supply in all theaters during the early war years have given rise to much criticism of the medical supply effort. The lack of adequate stock piles and the time required to expand production, the relatively small group of officers trained in medical supply procedures, other than station supply, the lack of equipment lists except those left over from World War I, which would supply information necessary to estimate requirements, insufficient shipping and the confusion of embarkation and debarkation all contributed to equipment and supply shortages experienced in Medical Department organizations at home and overseas. The encouraging feature of the supply situation was that progress in every direction was made as the war went on and in the later stages a medical supply system was developed which was second to none.

2. The problem of short supply of medical material in the United States was finally solved by expanded production though a number of items remained "critical" throughout the war. There is need for a study of the overall medical supply requirements of World War II upon which estimates of these requirements in a future conflict may be based. Such a study is a joint Army, Navy and Air Force responsibility and should be undertaken by a board of selected experienced medical officers. The findings and recommendations of this board should be submitted to the Joint Army, Navy Procurement Office where plans should be laid for the orderly procurement of the material needed by the Medical Department in the event of a future war. In developing such a program, attention must be given to civilian defense requirements.

3. The lack of a sufficient number of trained medical supply officers handicapped the development of an effective medical supply system. There are at present a large number of officers who had a lot of medical supply experience during the war. It is essential that this group of officers be maintained by the intensive training of new officers in the system developed in World War II.

4. The insufficient shipping tonnage was an important factor in medical supply shortages during the early years of the war. It was extremely difficult for the Medical Department to secure its required share of the available space. It was not until late in the War that this situation was relieved.

5. Until the summer of 1943 Air Force units frequently arrived overseas without their organic medical equipment. Redistribution of equipment of other medical units in the area led to overall shortages. The obvious remedy is the shipment of organizational equipment with or in advance of the personnel of the unit.

Split shipments of hospitals to the MTO and the Southwest Pacific was a source of much difficulty. Material of a given unit was frequently unloaded at widely separated points and had to be assembled within the theater. It is not practicable always to load all the equip-

RESTRICTED

RESTRICTED

ment of a given unit on the same ship. It is essential that later shipments be delivered at the same destination. A proposed system would charge the Medical Department with the responsibility of assembling all hospital organizational equipment, except motor vehicles, minimum essential and personnel equipment, of packing, marking and preparing complete documentation for overseas shipment.

6. Automatic medical supply in use at the beginning of the war led to heavy overstockage of many items at overseas bases. Some of the supplies were not needed at all, others were not used at the calculated rate of consumption. To avoid waste of material up-to-date medical supply tables are essential in making up automatic or block shipments. Such tables based on actual requirements of overseas organizations should be worked out and kept up-to-date. It is recognized that an automatic supply system is also necessary in supplying combat ships while underway in the course of prolonged operations at sea. Medical supply on the basis of requisition by all Medical Department organizations should be adopted as early in the campaign as possible.

7. Medical supply officers in some theaters reported difficulty in obtaining information about the arrival of troops in the area, upon which to determine medical supply requirements. Not infrequently it was necessary to depend on estimates which proved to be grossly inaccurate. Serious supply shortages developed and excessive inter-depot transfers became necessary. Instances of this nature did not occur where competent medical staff officers were present and the medical service received command support.

8. Hard won experience in the last war demonstrated the urgent need of an ample supply of whole blood in the combat area and in all hospitals. Troops in the overseas theaters can not be expected to supply the quantities required. The system developed in the last war of collecting the blood from volunteers in the United States and shipping it in chilled containers via air to blood distribution centers at advanced bases proved eminently satisfactory. Plans for a similar system to be ready for operation at the outbreak of a future war should be adopted. Responsibility for collecting, processing and shipping whole blood should be assigned to a special unit under the immediate direction of the Office of the Surgeon General. Shipments should be given highest air priority. Consideration should be given to the demand for enormous quantities of whole blood by civilian defense agencies in the event of an atomic war.

9. In the past war, the operation of separate Army and Navy medical supply services in overseas theaters was uneconomical and wasteful of personnel and supplies. Since there is a Joint Army-Navy Medical Procurement Agency and an Army-Navy Catalogue of Medical Material, either service could provide medical supply support for a theater or area through common Medical Supply Depots. The medical service having the larger force to support in any given area would establish and operate the depot from which all medical units in the area would draw their medical supplies. Responsibility for keeping the depot advised of the medical supply requirements of Army, Navy or Air Forces in the area would rest with staff medical supply officer of each of the Armed Forces. The principle of joint operation of medical supply services should be extended to overseas theaters.

RESTRICTED

RESTRICTED

II. CONCLUSIONS

1. Adequate stockpiling and plans for expanded production are essential for effective medical supply of the Armed Forces at the outset of a future war.
2. The lack of a sufficient number of trained medical supply officers handicapped the development of an effective medical supply system in the early part of World War II.
3. Insufficient shipping was a factor in medical supply shortages during the early war years.
4. The arrival of Air Force medical units overseas without organic equipment led to acute overall shortages. Split shipments of hospitals to the ETO and the Southwest Pacific gave rise to much difficulty in assembling the material from widely separated unloading points.
5. Automatic medical supply resulted in heavy over stockage of numerous items at overseas bases. The automatic system of supply is necessary early in a campaign but should be replaced by supply on a requisition basis as soon as possible.
6. Experience in the last war demonstrated the need for whole blood for the care of casualties in overseas theaters. Plans for a system of whole blood supply similar to that used during the last war should be adopted. The system should be ready for operation at the outbreak of hostilities. Responsibility for its operation should be assigned to a special joint medical unit.
7. The principle of joint operation of medical supply services by the Armed Forces should be extended to overseas theaters. Under the present organization of the jointly operated medical supply system, any service could provide medical supply support for all units of the Armed Forces in a given area.

III. RECOMMENDATIONS

1. That plans be developed for the orderly procurement of medical equipment and supplies needed by the Armed Forces in the event of a future war.
2. That the present group of experienced medical supply officers be maintained by the intensive training of new officers in the system developed in World War II.
3. That the Medical Department be assigned the responsibility of assembling, packing, marking and completely documenting unit medical organizational equipment for shipment overseas.
4. That an Army-Navy-Air Force Medical Department board be organized and assigned the responsibility of formulating plans for the supply of the whole blood from the United States to overseas theaters in the event of war.
5. That action be taken to extend the joint operation of the medical supply services of the Armed Forces to overseas theaters in a future war.

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E.R. HERING, JR., (MC) USN ON 22 APRIL 1948,
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** G. "I have not prepared a statement, but just something to guide me and I would like to say, first, that my experience was principally with the amphibious forces. By that I mean both the forces afloat and the forces ashore, with not only the Marines but the Army.

I was in the Central Pacific. I was astounded when I returned after the war to find in places the thinking regarding the efficiency of our forces. Everybody seemed to think we did a wonderful job and that no changes were indicated. The points I have made here are fairly general. I think our greatest lack, both afloat and ashore, was the lack of medical officers trained in staff work for amphibious warfare to understand the overall concepts and could direct the planning of the amphibious operations. I think that exists today; and certainly we aren't training anybody in this employment.

As an example of what happened, I would like to point out the employment of hospital ships and the LSTH's at Saipan. We were assigned for our support ashore three LSTHs. To my knowledge the designation of these vessels was changed six times between the fighting phase and the actual assault on the beachhead.

The LSTH which I observed personally did not take station at 2,000 yards off the beach as she was supposed to do shortly after H Hour, but commenced taking her casualties about 600 yards from the Monrovia, in the transport area 22,000 yards off the beach.

When I saw what she was doing, I attempted to get the transport squadron commander to leave the casualties which she was loading, come to the transports, which was their eventual destination, and have that ship proceed in where she could distribute the casualties off shore or give treatment to those casualties which couldn't safely be evacuated 22,000 yards.

It was impossible to get any action. She took 100 casualties aboard by cargo net, by individual litter hoist, by dragging them up with hoists, beachswains' chairs, and so on, and then, after two or three hours brought her whole 100 casualties over to the Monrovia, came alongside it, and it took two hours to transfer them, because there was no brow. We had to build one.

Of those 100 casualties, 15 were dead by the time we got them aboard the Monrovia. They had received absolutely no treatment, not even plasma, on that ship. Four more subsequently died that afternoon. I knew that, because I knew where they were buried. We brought them ashore the next morning.

The first hospital ship arrived at D-Plus-3, and thereafter hospital ships arrived at only irregular intervals. And our first intimation was when we saw one pull in at the target.

If a hospital ship is to be utilized at all on amphibious operations, it should be utilized at H-Hour, because with the element of surprise there is no more danger to a hospital ship at D-Day than there is at D-Plus-3. I am happy to say this was rectified, and the hospital ships at Okinawa maintained

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E.R. HERING, JR., (MC) USN ON 22 APRIL 1948,
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES, CONT.

a beautiful schedule and were certainly active. I don't know whether we didn't have them available at that time or whether it was due to poor planning, but they were certainly inadequate at the Battle of Saipan.

In an attempt at Tinian to provide adequate facilities afloat for initial casualty impact, we put two of my medical companies on APAs and designated them as casualty receiving ships. There was no medical officer on the staff of the amphibious force commander, with the result that those two ships were used for demonstration and were not available off the beaches. So we actually disseminated what medical support we had.

The lack of properly trained medical officers on staffs resulted in extremely poor coordination of medical resources ashore and afloat. For instance at Okinawa I attempted to get an LSTH to evacuate directly from Naha Harbor. Our advance there had been so rapid that the hospitals couldn't keep up. And, because of the rains, evacuation over the roads were absolutely impossible. We couldn't do it.

I don't want to go into all the details of difficulties I encountered in attempting to get a LSTH down there. But it was five days before we were able to get a LSTH in to get those casualties out of Naha Harbor.

A classic example which occurred early in the war through lack of cooperation between the forces ashore and forces afloat was the Kiska operation, although there were no Japanese there and the results did now show up.

I was present there during the planning phase and actually knew that the Army intended to take care of all their casualties ashore. They had three field hospitals, and they were going to set them up and take care of all their casualties. For an operation which involved 145,000 men in the assault and follow-up, we had one hospital ship. Maybe the Army was correct in deciding that they had to take care of the casualties ashore. As I say, fortunately we didn't have casualties.

For coordination of air evacuation at Saipan, my first knowledge of air evacuation facilities came on about D-Plus-7, when I was instructed by the corps surgeon to send 17 patients up to the air field. My concept of air evacuation at that time was very erroneous; and I sent some patients up there which I realized should not have been evacuated by air. So did two other Divisions.

There were no screening facilities at the airport. There were no medical personnel to accommodate the wounded. There were no medical facilities aboard the planes for treatment. We actually sent some of our corporals and doctors all the way back to Pearl Harbor, doctors and corporals that we needed for the operation. As a result, six of these patients during the first week died in transit, and we got a terrific blast. As I say, I feel it was my fault for the ones we lost, in that I didn't know the type of patient which could stand air evacuation.

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E. R. HERING, JR., (MC) USM ON 22 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES, CONT.

Likewise, after air evacuation was set up with good ambulance planes, we were forced to suspend air evacuation for a period of 10 days because they could not handle the casualties. We received instructions to delay our evacuations, which were vitally needed.

The status of offshore evacuation is, I might mention, back to where it was before the war, that is, they are attempting to distribute casualties from the beach, which, in the initial phases of the operation, cannot be done. It can't be done because you can't direct a coxswain to take casualties to ships offshore, because we don't know their status at the moment. We don't have communications. We have no assurance that the coxswain will carry out the directives. And, there is absolutely no provision for evacuation at night.

I wrote a little bit on what I would like to make as a recommendation. Perhaps that is premature at this time.

REAR ADMIRAL ANDERSON: No. I think we would like to have your comments your ideas on it, of receiving offshore evacuation, or the whole subject.

CAPTAIN HERING: I am speaking of the whole subject because it ties in.

The lack of training, the lack of modern doctrine which keeps pace with our changes in organization - the major reason for this is that there is no strong Department of Amphibious Medicine anywhere. There is one in the Bureau of Medicine and Surgery. That is on paper only.

Captain Haynes, who is a very well trained and excellent officer, has been loaded down with other duties so that we can't give any time to it. He has been, and will be, for the next four months, engaged in an operation outside the States, and there is just nothing being done. These problems are never even referred to that section.

I think this should be a joint medical section, because we must have the forces ashore and the forces afloat in the closest liaison and coordination. I feel, further, that this section should be in the Bureau of Medicine and Surgery, under their cognizance, because initially the ships afloat must bear the initial load of casualties. We must depend upon them initially in these violent amphibious assaults. But I feel that the Army must be represented because of the coordination necessary and also because I feel that the Navy should keep out of the field of temporary and semi-permanent hospitals. The Army knows how to do that much better than we do. They are trained from the time they are second lieutenants, or are being indoctrinated in the field, whereas we have relatively few that are assigned to our field medical forces - the possible exception, of course, is the medical sections attached to the organic combat units, in other words, the divisions, or possibly corps. But any back-up of hospitalization on the target, or in the immediate theater, should be an Army responsibility. We should utilize their great knowledge and planning facilities along this line. The Air Force should be represented because we know, especially in the last operation which I observed, Okinawa, our air evacuation; and that must be coordinated into the picture. The whole subject of amphibious medicine is dormant at the present time.

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E.R. HERING, JR., (MC)USE ON 22 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES, CONT.

Again referring to my particular employment, actually I cannot discuss the picture of medical resupply and initial supply prior to Captain Jordan's arrival in the Pacific, because it was so confused I didn't understand it.

I made out requisitions, sent them in, and they passed through a lot of hands that were not intimately connected, or realized the tactical or strategical situation. As a result, the urgency of those supplies was not appreciated by some of the elements that were supposed to resupply us.

Eventually, Captain Jordan did set up a system of supply blocks; and while they were not as accurate as they might have been, because nobody could be accurate on them, nevertheless from that time on our medical resupply was excellent. Since that time we have had a Medical Field Material Board at Camp LeJeune set up as a permanent board.

We have worked very closely with the Army. We have had two excellent meetings at Louisville and Camp LeJeune and are contemplating another one at Randolph Field.

We have gone over, from our standpoint, block requirements, the initial mounting out requirements, and our rehabilitation requirements following combat. We have developed, even listed, the items their way, and we have designated the responsibility for various command chains in the actual furnishing of this material at the target.

We were not able to come to agreement with the Army on this particular system and did not deem that too important at the time, because they are determining it for, more or less, large operations where they have large medical supply chains of their own, and we saw no way in which we could compromise the two.

I feel that for short, violent campaigns our system is superior, and I think, should be employed for that type of an operation. There again it shows the necessity of a high level joint planning board to take cognizance of the type of operation on which the military embarked and to set up a system of logistic support which fits that operation the best.

COLONEL POHL: Do you have a special medical supply unit that accompanies on the smaller scaled operations?

CAPTAIN HERING: Yes sir, we do. It is a section of our combat service group which goes along with us to the target, receives our material for resupply as delivered by the service forces of the fleet and in turn segregates it and passes it to us as needed.

Our one weakness at the present is that we have no medical supply section for field units which works in conjunction with a Marine supply. This has occasioned a wastage of medical supply, in that the Marines, especially in these unsettled times, are continually changing their logistic directives as far as the

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E. R. HERING, JR., (MC) USN ON 22 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES, CONT.

number of days and as far as supporting the number of men. There is no hardship for the Marines because they have, right there at their mounting up place, their own depot. So when they change their logistic directive it is really a paper change.

A stock level is maintained of those Marine Corps items, such as clothing, ammunition, and other things of that nature.

As I have no echelon between myself and Brooklyn, I have come, by necessity, to order medical supplies sufficient enough to cover the greatest contingency that I can anticipate regardless of logistic directive; and right now I find myself in a position of having, roughly, 30 day's supply for 18,000 men too much on my hands. I am reluctant to let that go at the present time because I don't know which way we are going to jump, and it's really my ace in the hole.

If we had a medical section in the camp supply depot where these requisitions on paper could be given to them as their responsibility, they could store these medical supplies for the greatest contingency, and they could cooperatively use them for all medical uses. The naval hospital could use up our x-ray film as it becomes outdated; the camp dispensaries with 18,000 military and civilian laborers, plus all the dependents, can use a tremendous amount of medical supplies. This could be continually turned over without wasting this medical supply, without allowing it to grow old in service.

This has also been recommended but turned down once, because the particular personnel allowance did not allow sufficient personnel for employment with the Continental Marines; and the compromise was reached, attempting to set this up with our element, the Second Service Combat Company. However, Captain Jordan has just recently recommended this again, and we hope that this time we will be able to set it up. It is only common sense.

It has another advantage, in that our strategic material should not be centralized all in Brooklyn, especially in view of atomic warfare.

I recommend that we put in a medical section in the camp depot which will hold a stock level of supplies, or maintain a stock level of medical supplies, which will take care of our logistic requirements as they may be changed or come up for different organizations, or as we have echelons of troops going out. The advantage is that we will have new supply. They will be continually rotating it, rather than take and store these things down here for years and be of no value. That refers, of course, especially to certain items which do have a deteriorable day on them -- x-ray films, biologicals, plasma, and things of that nature.

REAR ADMIRAL ANDERSON: Where are the reserve supplies stored now? They are under your control, aren't they?

CAPTAIN HERING: As Fleet Marine Force, Atlantic, they are. We have this 30 day mounting out and this excess which, as I say, I am maintaining.

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E. E. HERRING, JR., (MC) USN ON 22 May 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES, CONT.

We have, on authority from Captain Jordan, taken the major items which are deteriorable and submitted to him a requisition which he hopes he will be able to fill within five days and deliver to us at the mounting out area. That will be difficult, because they will just have to be bought supply rather than distributed among the units. We won't be able to distribute it among the ships too well. But it is the only answer at the present time.

Because of the shortage of x-ray films, we have got authority to TVI to the camp dispensary at the naval hospital in an attempt to conserve that, because it is worthless after six months.*****

L. K. P. H.
RECORDED
L. K. P. H., Colonel MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C. B. Camerer (MC), U.S.N.,
Retired dated 21 April 1948)

***** (g) Provide for an ample and continuous flow of all medical logistic support by surface and air with high priorities for such transport in active combat areas. Large depots to be organized as near forward as practicable and to be MOVED on forward as expeditiously as the military situation permits in order to have an ever ample supply of essentials within convenient range of forward activities at all times; a definite factor in strengthening morale, if for no other reason. Uniform procurement of supplies is stressed.*****

TRUE COPY EXTRACT (Letter, T. F. Cooper, USN, dated 19 April 1948)

***** "Medical logistics on the whole rated high during the last war. Medical material was furnished to the Pacific Fleet and bases by numerous shore based storehouses, medical stores issued sections on 28 AK and AKE type vessels plus eight barges. However, weaknesses in the system were obvious. Lessons learned during the war, insofar as practicable, should be placed in operation during the peace lest they be forgotten."*****

TRUE COPY EXTRACT (Letter, Brig. Gen. Robert C. McDonald, MC, USA (Ret.)
dated 15 April 1948)

***** (g) Medical Logistics in Military Campaigns.
"Medical units should have initial equipment and supplies sufficient to enable them to function 30 days under combat conditions. Rear echelons in the combat zone should have another 30 days' supply for each medical unit, and the communications zone should have an additional 60 days' supply for all units. Automatic medical supply for maintenance should be used only in the early stages of a campaign and until depots can be established in the Theater of Operations."*****

RECORDED
L. K. FOHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr Alfred W. Eyer, Captain (MC), USN, 17 April 1948)

**** "(g) Medical Logistics in military campaigns.

In general, medical logistics in the last war functioned on a basis that it was better to have too much than to chance too little. As a resultant, considerable wastage of effort and materials occurred.

In the South, Southwest and Central Pacific this may be attributable partially to the inability of the planners to foresee the rapid shrinkage of active combat into a relatively restricted area.

In the present day, all indications point to the fact that the wedding feast with natural resources is over; and that the consummation of marriage will be conservation. Hence, in the future, it will be important to have enough where possible; but not too much. This will call for careful, accurate preliminary and concurrent planning.

However, it is believed that many of the difficulties arose from the conception, widespread but without official confirmation, that all materials leaving continental United States were expended or expendable.

It is suggested that the maintenance of stock records, and accountability are prerequisites to good housekeeping. Further, the delegation of material surveying authority to Area or Force Commanders permits maintenance of a stock situation picture not otherwise obtainable, and the rapid accomplishment of business.

From the standpoint of conservation of medical personnel, it is not believed that medical officers should be assigned to small individual ships. Usually, these vessels lack facilities to enable the full utilization of a medical officer's talent. However, it is realized that this situation contains a definite morale problem which requires consideration.

In general, the smaller ships, destroyers and destroyer escorts, are operating with larger vessels which have adequate medical facilities. Intensification of training of Hospital Corps personnel for assignment on such ships, and Departmental enunciation of policy regarding medical personnel allocation might help to solve this problem." ****

RECORDED

L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTEDTRUE COPY EXTRACT (Letter, Captain J. H. Robbins (MC) USN dated 26 April 1948)

***** "(a) Original hospitals of the entire Pacific area were entirely inadequate as to size, personnel and equipment for the load placed upon them. Hospitals were originally of 400-bed capacity, but it is recommended that in the future all of these hospitals have a minimum of 1000 beds, preferably 1500 beds with standardized equipment.

"(b) Practically every one of these hospitals were erected by Medical Department personnel as no Seabees were available. Although Mobile Hospital #4 was erected and equipped in exactly 28 working days it was still a waste of valuable manpower, but shows what can be done if the proper spirit prevails. It is recommended that in the future erection of hospitals be done by Seabees.

"2. The Mobile hospitals mentioned above were prefabricated buildings of a separate and distinct type. In the event of future campaigns, it is recommended that the buildings assigned to Fleet and Base hospitals conform in type and construction to those used throughout advanced base areas. In other words, that all buildings be standardized.

"3. Many of the medical supplies such as drugs were in an extremely short supply and at times wholly inadequate for the patient load. While this shortage was partly due to lack of shipping, it is believed the basic error was in maintaining large amounts of these items, e.g. atabrine, quinine, merthiolate, sulfa drugs, etc., in the United States, as when enough pressure was brought to bear by the Area Commanders, this material arrived in adequate amounts.

"4. Surgical dressings (bandages, adhesive plaster, etc.) fell into the same category as the above. Surgical instruments were adequate with few exceptions. None of the Mobile hospitals had a Bovie electrical surgical unit. Most of the Army hospitals were equipped with this item. (Note: An individual attempted to donate an electric surgical unit to one of our Mobile hospitals, but was told by our Bureau that we had no use for such a machine and they would not authorize transportation). Another item of vital importance that was lacking was a bullet locator. Although practically every Army hospital in the area had two, of which luckily Navy was able to borrow one.

"5. Medical personnel in the hospitals was considered adequate for the authorized patient loads, but with the overloading, it was entirely inadequate. It is recommended that a proportionate increase of all medical personnel be indicated.

"6. Special equipment: All special equipment such as boilers, motor generators, galley equipment, etc. with their necessary appurtenances should also be standardized to conform to that used on the rest of the Base, in order that spare parts may be available and repairs easily and quickly made.****

*****"9. In any future campaign it is recommended that each medical department unit be limited to a standardized list of supplies and materiel especially when being moved to another area. (Note: During the redeployment from South Pacific Bases to the forward areas, practically no hospital unit could get their supplies and materiel down to the shipping limit allowed them for cargo space."***-404

RESTRICTED

K. F. P. I., Colonel, MC

RESTRICTED

TRUE COPY (Extract from Ltr Col. Harry G. Armstrong, MC, 16 April 1948)

**** "g. Medical Logistics in Military Campaigns.

(1) Defects:

- (a) Line officers set up medical requirements.
- (b) Failure to use staff surgeons in planning.
- (c) Medical supply system hooked into normal supply channels.
- (d) Medical cargoes on vessels not properly placed, (bed nets might be in the bottom of the hold).

(2) Remedies:

- (a) Medical personnel establish medical requirements.
- (b) Medical personnel supervise loading of cargo as far as medical equipment is concerned.
- (c) Medical Supply made part of tactical organization."

RECORDER

L. K. Pohl
L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee, dated 18 April 1948)

***** "(g) Medical logistics in military campaigns.

"The old concept of 6 doctors per 1000 men is certainly outmoded and should be revised. Here again the re-organization of the Medical Department to be completely airborne would make possible an entirely new and economical (in terms of medical personnel) concept of medical logistics." *****

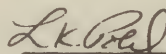
L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Robert W. Gillett (MC) USN
dated 15 April 1958)

***** "Frequently higher echelons attempted to prevent the free exchange of strategic materials between services in the combat zone. Such practices, at times, severely interfered with the proper handling of casualties." *****



L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Captain Lewis T. Dorgan (MC) USN)

***** "(g) Medical logistics in military campaigns

"The prevalent plan so often employed by various staff organizations of subordinating the medical department activities to a sub-group under general military logistics proved inept, and often, tragic. In formulating operational plans, line and supply corps officers often attempted to write the medical plan, including air and surface evacuation of the wounded, without consulting the Medical Officer until they ran into difficulties which their limited knowledge in that field could not surmount. They would then consult the Medical Officer, often too late for him to take the proper remedial action.

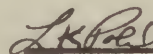
"Medical stores and supplies in the Seventh Fleet area during the New Guinea and Phillipine campaigns were practically non-existent. Almost all supplies were drawn from Army activities. It was late in the campaign before medical supply barges and "AK" block loads became available.

"Suggested Remedies:

"(1) All stores and storehouses should be joint Army-Navy. The Army should establish adequate facilities ashore and the Navy should move floating stores, either in barges or aboard supply ships, with each Fleet train.

"(2) The Medical Department should always be a separate department directly under the area or Fleet Commander, and never be subordinated to another department.

"(3) Medical logistics should be carefully planned in advance and senior officers should be responsible for coordinating plans between areas and fleets. Such officers would preferably be responsible only to CinCPac or CinClant." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain H. D. Templeton, MC, USN
dated 23 April 1948)

***** **"(G) MEDICAL LOGISTICS -- MILITARY OPERATION.**

At no time during the past war was I acquainted with any occasion in which there was not adequate medical logistical support. There were instances, however, during the planning stage that adequate hospital bed facilities were not being provided ashore. However, this situation was provided for by the employment of additional hospital ships and casualty beds on the troop transport; this method of support was more satisfactory than field hospital facilities ashore. In this operation it was fully realized and appreciated that the special augmented hospitals were not the type to be included in the early echelons supporting the invasion operation because of their tennage and construction. I mention this type of hospital only to recommend against its employment on future occasion, because their construction demands the services of construction battalions whose employment is greatly needed for more important duties with the combat troops. The tennage of this hospital is practically twice that of a field hospital which can be established and operated with considerably more ease and provide equally as well for the battle casualties.

The palatization of medical supplies is an ideal method of providing a flow of standard drugs and first aid equipment which were used in large quantities and to very good advantage.

As previously stated, all medical supplies and equipment were most adequate in quantity and quality. The sudden ending of hostilities resulted in large stock piles of medical supplies, but they would have been sorely needed had the war continued, and should be regarded as one of the losses of war which was in no manner preventable." *****

RESTRICTED

L. K. Pehl

L. K. Pehl, Colonel, MC 407

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Arthur B. Welsh, MC, USA
dated 19 April 1948)

***** *g. Medical logistics was a comparatively new term in World War II. Many fought the war without using it. Is getting the right patient, the right doctor, and the right facility together in the shortest possible time medical logistics? Too many people were inclined to become supply minded when they associated medical service with logistics. The problem that was major in scope for the Medical Department was personnel and personnel management. Medical logistics should have included personnel. World War II history must be studied carefully before criticizing the medical logistics of campaigns. Instances are few in which the medical service failed when there was command support -- provided competent medical staff officers were present. The Medical Field Service School can be proud of the World War II records of its graduates. They made medical logistics work. This lesson should not be forgotten and there is a tendency to do it. Possibly a 'board' can be established for the Military Surgeon if the medical profession of the country can be made to recognize that military medicine is a definite professional specialty. In addition to Regular Army Medical Corps personnel many civilian doctors could qualify. To further neglect training such individuals in greater numbers for World War III is a mistake. Some recognition might encourage doctors to volunteer for such assignments or for advanced training. Doctors desire to have outstanding doctors leading them in war. They abhor non-medical leadership. So let's develop sufficient leaders. Perpetuation of this system of developing medical commanders, logisticians, staff coordinators and planners as exemplified by the creditable performance of Medical Field Service School, Command and General Staff College, Industrial College, and Army War College graduates is the key to success in future warfare so far as the Medical Department is concerned. The Armed Forces Staff College has since been added. More doctors should attend these schools."*****

RESTRICTED

L. K. Pehl

L. K. Pehl, Colonel, MC

408

RESTRICTED

TRUE COPY EXTRACT

(Letter, Captain C. D. Morrison, Jr., MC, USN
dated 23 April 1948)

***** "g. Medical logistics in military campaigns.

It is believed that the logistical support during the war was one of the most outstanding jobs done by the Medical Department. The use of a combined Army, Navy air force supply table should add to this efficiency."*****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT

(Letter, Colonel Hervey B. Porter, MC, USAF
dated 23 April 1948)

***** "Lack of material resources and the heartbreaking effort necessary to make wants known through normal channels, and receive the necessary material through normal shipping sources (6 to 9 months). *****

***** "g. Medical logistics were ample if material was available. Under certain situations stoppages of certain items as plaster gauze became necessary." *****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

~~TRUE COPY EXTRACT~~ (Letter, Colonel F. A. Blesses, MC, USA, dated 19 April 1948)

******7. Medical logistics in military campaigns.**

"a. The logistical requirements for military campaigns cannot be properly ascertained without a careful study of previous campaigns, experience tables and their correlation with future plans, material and transportation capabilities. More thought should be given to such studies in time of peace and they should be incorporated in our advanced school curriculum as committee studies.

"b. In the past war the presence in overseas theaters of separate Army and Navy medical services was uneconomical and wasteful in personnel and supplies. If some centralized agency could be established in the zone of the interior to support overseas forces, medical logistics in military campaigns might be much more efficiently operated. The present system of joint Army-Navy medical supply procurement might well be expanded to all aspects of the medical services of the Armed Forces.

"c. There is a definite need for a board of selected, experienced medical officers for the over-all study of lessons derived from the last war. They should be free from other duties and be closely associated with the Planning Division of the Surgeon General's Office, the Office, Chief, Army Field Forces, and the Field Service School. Their recommendations should go to the Planning Division for further consideration and action when indicated. The present central Medical Department Board has no apparent function and should be reorganized and given a definite mission along such lines.

"d. Stockage of supplies and equipment for overseas operations should include the complete unit assembly of certain units to cover the complete loss of a unit, less personnel, due to enemy action. It was found to be impossible to make such complete assemblies from usual stockage and considerable time is lost before replacement can be received.

"e. Personnel must be better trained in maintenance of medical equipment. Much equipment was unserviceable because of minor repair problems which could have been corrected, or avoided, by properly trained mechanics.

"f. The percentage of hospital beds required for support of a field force in a military campaign is a subject which has caused considerable misunderstanding and difficulty. This should be clarified and a definite, top-level policy announced for the purpose of obtaining uniformity in all future planning and instruction. It is believed that the following facts must be

RECEIVED
L. K. Pohl

RESTRICTED

L. K. Pohl, Colonel, MC

410

RESTRICTED

TRUE COPY EXTRACT - Continued - Colonel F. A. Blesse, MC, USA

established as a basis for policy:

- (1) That, 'hospital beds' means 'fixed' beds.
- (2) That, 'fixed beds', for the purpose of this computation, includes only General and Station Hospital beds at their authorized bed capacity.

To arrive at a percentage requirement of beds for a field force, experience tables were compiled after World War I by Colonel Albert C. Love, Medical Corps, USA, and this was published as Army Medical Bulletin No. 24, entitled 'War Casualties'. This indicated a requirement, at the end of that war, approaching 15% of the strength of the troops. It was found, in the last war, that this estimate was excessive. This partly due to reduction in hospitalization time due to advances in medical treatment of casualties. From personal experience, I believe that 6% is a reasonable percentage of fixed bed requirements if all other medical units are excluded from this computation. This would place this estimation of requirements on a firm basis and eliminate existing misunderstanding. It must be remembered that considerable temporary expansion of these hospitals is possible without appreciable loss of efficiency.****.

RESTRICTED

L. K. Pohl

411

L. K. Pohl, Colonel, MC

RESTRICTED

Extract of Statements made by Brigadier General Raymond Dart, MC,
29 April 1948 before the Subcommittee on the Employment of Military
Medical Resources.

****There is another thing that is very important that comes to my mind and that is that cognisance be taken of the necessity for training the civilian component in staff duties. Today every emphasis is put on the professional aspects. Important as they are, you still have to have a certain number of men in the regular services as well as in the civilian components who have demonstrated administrative ability, who will be earmarked for early planning to go on the staff and get them out and get them trained in staff work.

From my standpoint to take a pathologist without any of this administrative training and go through with the responsibility for planning for a theater without this training, it isn't the most efficient way of handling it, and that has got to be recognized; and men who are going to do this planning should be training right now.

There are a number of things about supply that occur, the loading of ships, things of that kind that come up—if we are going to use ships. Those are things that, as I say, may have been only in our theater because we were sort of poor and benighted, but that is some of the things I would like to put down.****

RECORDER

L. K. Pohl
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY:

(Letter from Capt. Warwick T. Brown, (MC), USN
dated 20 April 1948)

***** "g. Medical logistics in military campaigns.

The basic logistical functions of supply, transportation, construction, maintenance and repair as applicable to the Medical Department in the combat zone and the communication zone need a great deal of study, development, and codification, during intervals between wars. Medical supply tables based on the requirements of the combat zone should be worked out and kept up-to-date. During the last war in the Fleet Marine Force in the Pacific, medical supply tables based on the requirements of 3000 men for 30 days were developed for initial supply, combat resupplies, malarial control supplies, and dental supplies. These tables should be brought up to date. Construction, maintenance, and repair units, such as the See Bee units, assigned to advance base hospitals and hospitals of the size corps evacuation hospitals in the combat zone would save an enormous amount of time in the setting up of these hospitals. Proper direction of medical logistics in the combat zone will be afforded if the training referred to in sub-paragraph (b) is carried out. Medical officers in general do not understand the administration of medical organizations in the combat zone. *****

RECORDED

L. K. Pohl
L. K. Pohl
Colonel, U. S. Army

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert K. Simpson, USA (Ret.)
dated 1 May 1948)

***** "(g) Medical logistics in military campaigns. I do not feel qualified to offer any criticism nor suggestions other than to express an opinion that aircraft and the parachute could have been employed in the delivery of medical supplies to units within the theatre of operations more than they actually were."*****

L. K. Pohl

L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter Capt H.P. Knakel, (MC), USN, dtd 21 Apr 48)

***** "G. From my observation during World War II, medical logistics were well worked out, excepting where the medical department was not kept abreast of planned campaigns. This is a very important factor. It is my opinion that the staff work of the medical department could be improved upon. Whenever campaigns are being planned, staff medical officers should be in attendance. I understand this was not always the case when campaigns were planned during World War II." *****

L. K. Pohl

L. K. POHL, Colonel, MC


RESTRICTED

RESTRICTED

TRUE EXTRACT COPY:

(Letter from Colonel Richard T. Arnest, Ret.
dated 19 April 48)

***** "g. This is a highly controversial subject and a ready solution is not available. The movement of medical units and supplies were given a low priority by certain commanders, thus rendering the medical situation acute at times. The medical service in a theater of operation should have control of sufficient transport to handle the movement of its tactical units and supplies. The logistic of landing operations is particularly difficult and no set pattern can be prescribed. When establishing a new theater of operation a system of automatic supply is essential for the first 8 to 12 weeks until a definite requisition basis can be established.//*****



L. K. Pohl
Colonel, U. S. Army

TRUE COPY EXTRACT (Ltr Capt E.R. Hering (MC) USN, dtd 17 Dec 47)

***** G. "Lack, early in the war, of full-fledged department of amphibious medicine in the Bureau. This lead directly to a failure of concerted effort in planning, assignment of personnel and the development of modernized doctrine and equipment. Later a liaison officer for field medicine with Marine Corps Headquarters was given a place in the Bureau organization and to the best of their ability, Captains Brown, Moore, and Haight attempted to fill our needs. It would appear that a field demanding intricate strategical and tactical planning and logistic support, and upon which is placed the care of thousands of casualties in a short space of time, deserves a place of importance at least along with space of time, deserves a place of importance at least along with that of Flight and Submarine Medicine. While exceedingly valuable and necessary in research and development, nevertheless, in battle both of these fields assume a more static role than does Amphibious Medicine. One recommendation which I believe of utmost importance has to do with Medical Supply. I did not include this under paragraph 4 because prior to the time Captain Jordan took over at ComSerForPac, our supply channel was so devious I never did understand it. A system of medical supply should be worked out in which as closely as possible parallels Marine Corps supply channels, with medical supply sections in major Marine Corps Depots. Captain Jordan concurs in this recommendation.*****



L. K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M. J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

**** "(g) Medical logistics in military campaigns.

I am not qualified to speak on this subject as it refers to the Medical Department and organization of the army, but I do believe that our own medical logistics were well-conceived, well-implemented, and efficiently executed. Planning on Bureau level was sound. Obviously some degree of criticism can be leveled at any undertaking or plan. Supplies and equipment were already available in fair quantities in the Pearl Harbor area at the time of the attack. Our own vessel, the Solace, carried in its medical storerooms the supplies and material adequate for two years of so called normal operation. In a very short time after hostilities began medical supplies and equipment flowed out to us in an every swelling stream. We were thus able to load our ship to capacity with these needed articles and transfer them to Medical Department Units in the forward areas. (Another important mission of a hospital ship).

Some material was forwarded by aircraft. At any rate our units seemed to have pretty much what they needed. Due allowances must be made for destruction and loss of supplies and equipment during combat. Early in the war when we lacked a sufficient number of ships, docking and unloading facilities, some of our medical units were delayed considerably in establishing their hospitals. This situation improved as time went on. We should be able to do a better job next time unless our material and personnel resources become seriously reduced.*****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain R. F. Sledge (MC) USN
dated 26 April 1948)

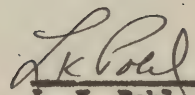
***** "Medical Logistics in Military Campaigns.

"Since there is a Joint Army-Navy Medical Procurement Agency and an Army-Navy Catalogue of Medical Materiel in which a large percentage of items are common to both services, either service could provide medical logistic support for a given campaign through common Medical Supply Depots and Storehouses. However, the where, when, what and how much for Ground Forces should be the responsibility of the Army; for Forces Afloat and Shore Base Naval Forces the responsibility of the Navy; and for Air Bases the Department of Air. When Bases are to be used by more than one service, the service having the greater force to support or having the controlling command should provide logistic support after the base is once established.

"Support for Military Government should be furnished in accordance with policies determined by the Joint Chief of Staff.

"It is believed that above plan will work however great care will have to be exercised to prevent areas such as New York and Oakland from assuming too great a portion of the overall workload. Even greater care will be necessary in the case of a national emergency to prevent the above named medical supply facilities from becoming a bottle-neck if the proposed joint medical supply depot operations is adopted." *****

RESTRICTED


L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

**** "g. Medical logistics in military campaigns. The moving, quartering, and provisioning of medical department installations should be the responsibility of the Force or Forces to which they are assigned, with a definite understanding of the special needs of the medical department by the Theater Commander or the Commander under whom they will operate." ****

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus (MC) USN
dated 27 April 1948)

***** "The problem of providing logistic support in any military campaign is the problem of getting what is wanted, where it is wanted and when it is wanted. During the early stages of World War II many items required in logistic support of the fighting forces were not immediately available or were in short supply. Just as in other fields of preparation for prosecuting the war on a scale and in the areas of extended combat, the medical department, early in the war, found it necessary to extend procurement, develop new equipment and create facilities for meeting new situations overseas. As the war progressed great advance was made in every direction and with the tempo of production greatly increased, the 'What' was needed became available in sufficient quantity. Hospital facilities for overseas bases, hospital ships and sources of medical supply were at hand with special provision for saving life such as the delivery of whole blood at the front became routine. Facilities for the evacuation of casualties by air were perfected and in general the 'Where' and 'When' of medical logistic support was fully met. Again it is difficult to comment on specific controversial points without knowledge of what they may be." *****

RESTRICTED

L. K. Pohl

418

L. K. Pohl, Colonel, MC

RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT
HISTORICAL RECORDS OF WORLD WAR II. (IAS Area Comd. 1943)

***** "At Casablanca, the initial problem confronting the Section was obtaining and distributing supplies. The confusion of embarkation and disembarkation frequently resulted in medical equipment and supplies being lost or misplaced, and not infrequently misappropriated the survey of units for T/BA equipment was instigated. At first this required actual contact with the units, in the field, visibly ascertaining the amount of equipment on hand. The problem was made more difficult by the fact that the majority of Medical Officers and unit supply officers, had no exact knowledge of the authorized quantity of equipment allocated to them by given T/O and E's. Therefore, a task not rightfully belonging to the section had, of necessity, to be assumed by it, if equipment and supplies were to be properly distributed. This was the formation of equipment lists for all the various units in the service command, and all air force units serviced by the I Air Service Area Command (Special). This was accomplished and the initial complete inventory finished in April 1943 indicated an overall shortage of 40% in authorized T/BA."*****

(IASAC - 1943)

***** "Survey of such units (fighter and bomb. sqs disembarking at Casablanca) frequently revealed extensive shortages in equipment. The records of the section indicate that it was not until June 1943 that units arriving at Casablanca from the United States were doing so with their organic medical equipment with them, or dependably allocated to them at some other port in North Africa. But throughout the first 6-7 months of the North African campaign, it was the frequent experience of this section to be told by tactical unit surgeons and supply officers that they had been told at the point of embarkation that equipment would be obtained in Africa. Follow-through on this statement was made irregularly or not at all, and just what it implied was not known. Was the equipment actually shipped from the port of embarkation, did it have the unit task force number, or was it turned in as excess in the United States, and therefore would not ever arrive in North Africa? The answers to these questions often were not known. The result of these misunderstandings was, of course, to produce a vast amount of what should have been avoidable interdepot shipments. Further, in an effort to forward tactical units with at least enough equipment to carry

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

(g)

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT
HISTORICAL RECORDS OF WORLD WAR II. (IASAC - 1943 - Continued)

on essential medical care, service command units were stripped of their equipment. In June and July, 1943, for example, records show that only 40% of authorized ambulances were available to the I Air Service Area Command (Special) Units and that other T/BA equipment was just over 50%. However, during these same months of 1943, the slack was taken up so that by August of the same year, we could show ambulances as being 85% complete and T/BA 75%. Meanwhile, other functions were being continued." *****

L. K. Pohl
RECORDED

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

Extract of Statements made by Brig Gen Robert C. McDonald, MC, USA (Retired),
21 April 1948, before the Subcommittee on Military Medical
Resources.

****"Automatic medical supply for maintenance should be used only in the early stages of a campaign and until depots can be established in the Theater of Operations."

We started out in this world war with automatic maintenance of supply, and I think we wasted a lot of supplies. I think that a lot of supplies went into theaters where they weren't needed at all, and units simply were overrun with supplies. They weren't using them at a rapid pace. And I think we got down to the logical way of getting supplies as they were needed by requisition of semi-automatic, or simply by requisition.

"Should equipment of medical units always accompany the personnel of that unit in overseas movements?"

It certainly should, if practicable. But I don't think it should be essential in a well organized transportation system. We did have a lot of difficulty in World War II in getting medical equipment of the unit sent altogether. The policy was, of course, to put all the equipment of a unit on the same boat. But the longshoreman took it in hand; and when they finished up a boat, they put the rest of it on the next boat, even though the next boat was going to another port. We had great difficulty in Australia of getting parts of a unit in one port and the rest of it in another. I think that should be handled by adequate supervision of port transportation. I think that was the fault. I don't think it should be necessary that the unit equipment has to go right on the same ship. If practicable, I think it would help. But certainly if something has to be left out from the ship where the personnel are, it seems to me there are many other things, perhaps of more importance than the medical equipment of the unit. Perhaps in planning you could get that equipment over there before they got there. In many instances you can get it there and have it at the point they have to be. That would be still better.

"Will atomic warfare increase our total medical requirements? Do we need any special units for this or a general overall increase of present units?"

We may need some special units. But I think that we would not need a general overall increase of medical units. Strangely enough, the casualty rates in combat units having varied very much from the time of the Greeks to the present time. I don't think that we will have so many more casualties among the armed forces than we had in previous wars. Maybe we are going to have the casualties among the civilian population.

"Did we have sufficient hospital ships? Should we rely more on air evacuation especially early in any future war? Should the medical departments have control of air evacuation units in all echelons including that of returning cases to the ZI?"

RESTRICTED

RESTRICTED

We didn't have any ships for a long time. In the later stages of the war, I think we had sufficient hospital ships. We did not have an adequate number of hospital ships until later in the war.

I think air evacuation is very, very important, and will be used to large extent in all stages of future wars.

I am not qualified to comment on the control of those units.

"What can we do to assure air evacuation early in any future war?"

We can arrange for the use of modern commercial air lines converted into ambulances. I feel sure that air evacuation will be used in any future war. Of course if we have adequate planning by the Air Force and these transport planes can be fabricated to be ready, it would be the best way that I know of to be ready for it.

"Was communication between medical units satisfactory in the combat zone? Do you advise radio in all field medical units? If not, why not?"

I don't know how that worked -- I wasn't fortunate enough to be over there. But I certainly do think that important medical units should have the advantage of radio.

"Should the supply of whole fresh blood be made a responsibility of our medical supply services? If not, who should handle it? Laboratory? Do you favor all supply of this item to come from the Zone of the Interior? If not, what suggestions do you have for a collection system in a theatre? Who would operate this collection system? The supply or the laboratory sections?"

I think, in general, the laboratory sections should collect and distribute the whole blood. I have had no experience along that line. If the Red Cross campaign to supply all the blood the whole country needs is developed, I don't think we will have any trouble of getting plenty of blood from the Zone of the Interior.

"In what items were you in short supply during the war? In critical supply to the detriment of the sick and wounded? "

That is more for the theatre. We were very well supplied in the service commands.

"Did we waste medical supplies? How could this be prevented? Were any items in constant over supply?"

I think the automatic system used for a while probably caused a wastage of supplies to Australia and perhaps to other theaters. But I know of no general waste of supply in the Zone of Interior.

"Is there any change indicated in our principle of placing the responsibility for evacuation on the next rearward echelon? If so, what do you recommend specifically? Did air liaison operate adequately? If not, what change is

RESTRICTED

RESTRICTED

indicated? Should the medical department return recovered cases to their units? Should G-1 continue to bungle the problem? What was the result of G-1 fumbling in this responsibility? What is your suggested recourse in the premises?"

I think that the primary responsibility is on the rear echelon. But certainly the forward echelon has the responsibility of seeing that they get back, even to the extent of taking them back, if it has to."****

RECORDED
L. K. POHL
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAF IN THE EUROPEAN THEATER OF OPERATIONS
HISTORICAL SECTION - AFTAS.

***** 8. "The administrative difficulties engendered by the scarcity and improper distribution of medical personnel were intensified by the lack of supplies and equipment and their improper handling or supervision. The severe shortage of organization medical field equipment, such as Dental Chest No. 60 and Flight Surgeon's Examining Chests, was due either to loss enroute or to the fact that such equipment was issued to the units prior to the departure of the troops from the United States.

For several months during 1942, 90-day medical supply replacements for 15,000 Air Force personnel were secured from the United States and sent to the Medical Supply Platoon, Aviation, for distribution to the units which first arrived in England. Efforts on the part of the SOS to take over this depot were forestalled by strong representations on the part of the Commanding General, Eighth Air Force Service Command. We succeeded not only in securing the privilege of operating this depot under the name of the Eighth Air Force Medical Supply Distributing Point but the authority to establish small medical supply distributing points at certain advanced Air Force depots.

Fortunately, by the time of the invasion of Europe, air evacuation was out of the theoretical and controversial stage. It had weathered the objections of the skeptics of both medical and line.

The two chief problems appeared to be communications and supply. For air evacuation to function efficiently, it is necessary for the coordinating officer to know the number of patients ready for evacuation at each forward area, the available hospitals in the rear areas, and the availability of planes in the forward areas and the arrival time of such planes. Then it is necessary for the coordinating officer to advise the forward areas of the number and expected time of arrival of the planes, provide each pilot with the destination of his patients, and to inform the receiving area of the number and expected time of arrival of the patients. In an amphibian operation, such as the invasion of Sicily, when ordinary means of communication are not available, special problems of communication exist which must be solved in order to prevent the breakdown of air evacuation.

Attention was called to three major controllable factors which determined the number of casualties evacuated by air. These were: the staff policy of limiting evacuation to returning freight carrying aircraft; the restriction on the use of tactical air fields by transport aircraft; the reception facilities in the United Kingdom. In addition to the controllable factors, there were weather conditions and the limited facilities of the holding units on the Continent which had to be considered. On the basis of reception facilities in the United Kingdom it was concluded that daily air evacuation for American casualties could be increased 500 percent. This study therefore recommended that air evacuation facilities be made available for the evacuation of the majority of the casualties from the Continent to the United Kingdom. This recommendation was approved by G-4 and by the Chief Administrative Officer. The facilities, however, were not immediately forthcoming, as will be seen later.

For these reasons, General Hawley concluded that evacuation by air was the only "proper" method. His reasons for the unreliability of air evacuation to this date are quoted in full:

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - APTAS, CONTINUED:

(a) The medical service has been unable to effect a liaison with the Air Forces which is effective. There are so many echelons of command involved that it takes more than a week merely to make contacts.

(b) Evacuation of casualties by air has no priority at all. Except upon one or two occasions, it has been impossible to evacuate casualties by air unless supplies were being carried forward by air. Consequently, evacuation is completely dependent upon supply. Where there is no supply by air, there is no evacuation by air.

(c) Evacuation by air is interrupted at such times as tactical operations by air are contemplated.

(d) All planes engaged in air evacuation are based in the U.S. Consequently, air evacuation depends not alone on the weather in France, but also upon the weather in the U.K. There have been, and will be, times when flying is impossible in the U.K., but quite possible in France. However, no evacuation within France is possible at such times.

To remedy the shortcomings in the air evacuation system as pointed out here, General Hawley recommended that air evacuation be given a definite status; that air evacuation be made a separate mission which would not be entirely dependent upon resupply by air; that sufficient aircraft be made available and based in France for evacuation here when weather conditions prohibit evacuation to the United Kingdom; and that a chain of communications be established in which the Chief Surgeon, ETO, could inform the responsible commander in the Air Forces of the necessary requirements.

The inability to get planes on a lower echelon of command, with the resulting threat of a complete breakdown in the whole system of evacuation of casualties, destined the issue a consideration by the Supreme Commander. As a result of the withdrawal of all C-47 planes of the Troop Carrier Command from air evacuation without notice, according to General Hawley, the evacuation became critical immediately. In a memorandum to the Commanding General, Combat Zone, 20 September 1940, he warned that "unless decisive action is taken without delay" the whole evacuation system would be stalled. Owing to the fact that the backlog of casualties was increasing at an alarming rate, he requested an assignment of 200 C-47 planes for evacuation until the backlog of patients could be cleared out. Again, he kept hammering away at the reason why air evacuation "had been most unsatisfactory"; the complexity of control of planes and the fact that evacuation had no priority.

General Hawley advised General Kenner on 21 September of the failure of his efforts to get the necessary planes allocated to relieve the evacuation situation. As of this date an estimated number of between 6,000 and 7,000 casualties was awaiting evacuation, the majority requiring immediate definitive treatment and whose condition "is steadily deteriorating". The Commanding General, Communications Zone, had presented his requests for the temporary use of 200 planes and for the indefinite assignment of 50 C-47 planes for air evacuation to the Theater Commander, with the answer that it was doubtful if any planes could be furnished, and that other means of evacuation should be used. With reference to "other means", General Hawley stated that, with the exception of three

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - APTAS, CONTINUED:

hospital trains of a daily life of 500, "there are no other means." He concluded his memorandum with this statement: "I do not know whether or not the Theater Commander fully realizes the seriousness of this situation".

Lt. Gen O.H. Bradley called the evacuation problem to the attention of General Eisenhower on 25 September, 1944. The long lines of communication in the US sector, he said, made air evacuation a necessity; that they had not "been able to overcome the difficulties introduced by sudden and complete withdrawal of aircraft for proposed airborne operations," because land transportation could not be efficiently and quickly produced; and, therefore, he requested that "a minimum of 40 C-47 aircraft be firmly allotted to the mission of evacuating casualties from Twelfth Army Group.

General Bradley was advised that the only C-47 aircraft which could be allocated to the evacuation of casualties were those of the Troop Carrier Command or those of the 302 Transport Wing, Air Service Command, USSTAF. The mission of both of these agencies was operational and to reassign the function of these agencies would be at the expense of operational needs. It was pointed out that a large number of C-47's from the Troop Carrier Command were engaged in emergency supply to Army areas and would be available for evacuation until such time as they would be required by the First Allied Airborne Army. A statement on air evacuation policy was made as follows:

Air evacuation of casualties must be considered as a bonus to be available from time to time as conditions permit and not as a scheduled lift to be available under all conditions. Even if not interrupted by operational requirements, it is subject to interruption without warning, and for indefinite periods, by the weather, and any evacuation system based on aircraft transport will break down.

Although every one concerned was in agreement that operational requirements should have priority over the evacuation of casualties, experience showed that air evacuation played a very important part in the system of evacuation. If it were assumed that an evacuation system were based on air transport alone, it could reasonably be expected to break down under certain conditions. It should be noted, however, that there was never any intention of basing the evacuation system on air transport alone. Considering the SHAEF statement in the light of the actual number of casualties evacuated from the theater by air, it shows a lack of appreciation for this method of evacuation, to say the least.

Lt. Gen. W.B. Smith, C/S SHAEF, to Lt.Gen. John C. H. Lee, CG, Com Zone, 21 Sept 1944, subject: Medical Evacuation states: Although SHAEF policy on air evacuation remained the same -- that air evacuation must be considered a bonus and was dependent upon resupply -- there were enough unofficial variations in this policy on lower echelons to move the patients who had to be evacuated.

Although efforts to secure the allocation of C-47 aircraft for exclusive use in the evacuation of casualties were never successful, General Grow did succeed in getting a squadron of 20 UC 64 planes for purely medical purposes.

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS, CONTINUED:

These planes had been relatively inactive because they were not very satisfactory for resupply, nor were they particularly well suited for the evacuation of casualties. They were based at Le Bourget Airdrome and used to carry critical items of medical supply to forward areas and bring back patients on the return trip. Each plane was equipped with litters to accommodate three patients, and there was room for two sitting patients, the pilot, and surgical attendant. Notwithstanding operational and structural difficulties with these planes, much important work was accomplished with them. During the period from 23 September through 29 December 1944, 36,008 pints of blood, 387,918 pounds of miscellaneous cargo, and 567,059 pounds of medical resupply were transported, along with the evacuation of 1,168 patients.

There were only seven patients who died in flight during the period from January 1944 through September 1945. During the period from June 1944 to 22 June 1945 there were 391,012 separate patient movements. Although the 7 deaths occurred over a longer period, using the data for the latter period would make a ratio of 1 death to 55,859 patient movements. Considering the types of casualties evacuated, the seven who died in flight probably would have died anyway.

Air evacuation made it possible to bring casualties to hospital facilities far behind the front, thus enabling medical staffs and medical equipment to be made use of in a far more economical manner. But, above all, the rapidity of the transportation of casualties to a hospital tremendously increased their chance for survival. When one considers that from the beginning of the war through 1946 there were 1,356,618 separate patient movements in all theaters and the Zone of Interior, one is likely to agree with the position of the former Air Surgeon (Maj Gen D.H.W. Grant) that "air evacuation of the wounded, as a life-saving measure, ranks with blood plasma, front-line surgery, and modern medicines of the sulpha and penicillin types for, without the rapidity of movement which air transport provided, even these measures would have been unable to save many lives which were saved.*****

RECORDED

L. R. POHL
L. R. POHL, Colonel. MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Extract of statements made by Colonel Thomas J. Hartford, MC, USA on 23 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

**** "g. I have worked on that a lot, of course. The only thing I would like to say relative to supply is that you should go to a requisition method of supply as soon as possible; that automatic supply may be necessary in early operations of block supply and all of that is just names and nomenclature; but in order to conserve supplies, that you should go to a requisition system just as soon as possible. That's my only idea on that.

"Did lack of land transportation hamper the medical service during campaigns?" I would say it was generally satisfactory; that you can't give medical units all the transportation they need to make them fully mobile, and there would be a waste of transportation if you did. *****



L. K. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain W. D. Small, (MC), U. S. Navy
dated 5 May 1948)

*****8. (a). Hospitalization in the combat zone was most effectively implemented by the Army evacuation hospitals. They were superior in equipment and staff to the Army field hospitals and should be the basic pattern for future developments. The Navy G-6 was not adequate in either composition or personnel in comparison with the Army evacuation hospital. An extemporized version of the latter type was hastily assembled in 1944 for the Marine Corps. Three such hospitals were organized and functioned fairly well. They were, however, too bulky and had too much heavy equipment. Specialized professional personnel for such hospitals should be provided from appropriate specialist teams.

(b). Hospitalization in the supporting areas was most effectively provided by the Navy's fleet and base hospitals. Comparable Army installations while less costly and of less weight did not possess the necessary facilities and equipment for maximum service to the patient or welfare of the staff. Army medical officers serving on CinCPac's staff were at first quite critical of the Navy's G-2 and fleet hospitals as being too heavy and providing too much comfort at the expense of mobility and rapidity of construction. However, toward the end of the war, after the Seabees had learned how to put up these hospitals with efficiency and speed, the Army procured a large number of Quonset huts for the construction of hospitals. In any future war, all such hospitals should be of one type of construction and it is believed the Quonset hut type is more practicable.

(c). Evacuation was grossly inadequate early in the Pacific War. The delay in authorizing and in assigning sufficiently high construction priorities to hospital ships was a glaring defect and but for good fortune could have resulted disastrously. The utilization of APA's as makeshift hospital ships should not be repeated. The personnel of such ships deserve great credit for outstanding performances and for preventing a very possible national scandal. The development of efficient and safe air evacuation later in the Pacific War gave us the most effective means of rapid evacuation we had. It is, however, a very costly method but in the future, if planes and fuel are adequate, will probably replace surface evacuation to a large extent. It is worthy of note that many patients interviewed by me, who had been wounded in the early campaigns and evacuated by ship only to be again wounded in later operations and evacuated by air were practically unanimous in preferring air evacuation.*****

RESTRICTED

W. D. Small
W. D. Small, Colonel, MC

429

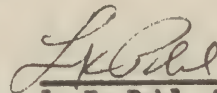
RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. R. Urban (MC) USN
dated 28 April 1948)

***** (g) Medical logistics in military campaigns.

"(1) Should be revised to accommodate casualties of mass destruction weapons.

"(2) Poor staff planning in relation to consumption rates of individual items of medical supply, e.g., too much cotton and gauze, too little antiseptics, fungicides, etc." *****



L. K. Pehl, Colonel, MC

TRUE EXTRACT COPY (Ltr LtCol Walter J. Reuter, Dental Corps, dtd 11 May 48)

***** C. "Dental Prosthetic Service. a. Deficiency - In foreign theaters it was generally the policy that hospitals and other dental laboratories (none Air Force) provide the dental laboratory service. Facilities provided were generally considered inadequate. Units too often were located too great a distance from these facilities, or mail service was too slow to successfully utilize them. b. Unfavorable Effects - A patient admitted to a hospital for construction of prosthetic appliances occupied a bed in the hospital for days although he was an otherwise healthy individual. During this time his services were lost to his unit. Cases sent to laboratories for processing too often were returned after an interval of time which materially reduced the usefulness of the appliance. g. Recommendations - That Air Forces be authorized to operate dental laboratories - mobile and fixed.

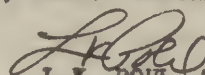
Field Equipment. a. Deficiency - The MD Chest 60 provided an array of dental instruments for the dental officer, but was sadly lacking in several essential items, chief among them being a good light, essential elevators for exodontia, a small dental cabinet and an electrified engine. To this may be added a small, lightweight cuspidor. These items are obviously desirable as they were almost invariably improvised in the field. Items furnished in the MD Chest 60 were crudely packed with apparently but one consideration in mind, that being to pack a maximum number of items into it. In the field, however, it served no useful purpose except for storage, and a dental cabinet had to be improvised to hold the many individual items when not in actual use. b. Unfavorable Effects - Upon arrival in the field, dental officers are faced with the problem of operating under severe handicap or improvising the items mentioned in a above, resulting in a loss of operating time. Items improvised at best were still quite inefficient compared to what might have been furnished and the dental service correspondingly lowered in quality and quantity. g. Recommendation - That field equipment be developed which will include 1) an operating light 2) electrified

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY (Ltr LtCol Walter J. Reuter, Dental Corps dtd 11 May 48. CONT.

motor, 3) a more complete set of surgical instruments 4) a small, lightweight cuspidor with tubing for running water and drain, 5) a small dental cabinet for instruments.*****



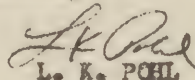
L.E. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract fr Ltr Albert T. Walker, Captain, MC, USN, 26 April 1948)

**** "During the last war, logistic problems in maintaining overseas hospitals were tremendous and used up a great deal of valuable shipping space. High-speed ambulance ships would provide rapid transportation from the combat area directly back to the source of all equipment and supplies (the zone of the interior) and would be able to return to the combat area with much needed medical supplies. The setting up of so-called mobile hospitals should be kept at a minimum.


L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Ltr Capt. M.S. Mathis (MC)USN, Dtd 6 May 48)

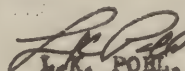
***** G. "I shall comment on this only from the standpoint of supply. In the Pearl Harbor area the Medical Officer in charge of the Supply Depot had difficulty in acquiring information on which to base his logistics. From October 1943, when the Depot began supplying everything within its reach until the latter part of 1944, there was no one place or officer to whom the officer in charge could go for necessary information. Information was solicited from the Fleet Medical Officer, Base Force Medical Officer, District Medical Officer, Medical Inspector for BuMed and eventually the District Supply Officer. Supply logistics were made from an estimate of the situation based upon information received from all the sources. This method was inaccurate and on one occasion the results brought near disaster. Feb. 1944 the Force surgeon gave estimated requirements for the fleet and forward areas, by month for the year 1944. In May 1944 it was accidentally learned that the fleet in May was approximately double the size anticipated for December. A rush request for a tremendous increase in supplies and equipment, produced consternation in Brooklyn and resulted in considerable shortages for about two months. Fortunately the Army was able to come to the Depots assistants in meeting most of its lacking requirements. Another near calamity was averted by and received from the Army between August and October 1944 due in most part to three factors; 1. Faulty technique in forwarding of back orders on items out of stock in Brooklyn; 2. Logistics forwarded from BuMed to Brooklyn not keeping up with those in the Pacific and 3rd, Brooklyn's faulty adherence to logistics based on past performance with insufficient credence given to logistic support from the area. These difficulties were all corrected after an inspection by the Chief of Mat. Div., Nov. 1944 secret information was made available to the Depot and dependable information from the Fleet and Force Medical Officers began to be received from which accurate logistics could be made. Recommendations; 1. Medical logistics be formulated by the Force Medical Officer. 2. Medical Supply Officer be kept currently informed on medical logistics. 3. Medical Supply Officer formulate logistics for supplies and equipment. 4. Medical Supply Officer for area keep Mat. Div. currently informed on area logistics. 5. Alternative to 1, 2, 3 or 4: Give Medical Supply Officer sufficient rank to admit him to the source of in-

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Ltr Capt M. S. Mathis (MC) USN, Dtd 6 May 48) CONTINUED:

formation. I believe all personnel who are to be assigned duties in connection with procurement and distribution of supplies and equipment and logistic support for same, should have a minimum of six months preliminary training. Medical Officers not to be assigned such duties should be briefed on the above during their indoctrination period in order that they become familiar with methods of procurement, places where supplies and equipment can be procured, quantities and types required for the mission and lead time required. Many difficulties were encountered during the early part of the war, due to medical officers lack of information on this subject.*****



L.R. POHL, Colonel, MC

RESTRICTED

(g)

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** "(F) 8. No. 80% of all casualties were evacuated from the mediterranean theater of operations throughout the year 1943 in personnel ships. I think the basic requirement in hospital ships should be provided for during peace because it takes from one to two years to get any hospital ships off the lines and their priority for construction is low, consequently it was over two years before hospital ships in any numbers appeared and even then the number was inadequate. I do not believe we should rely on air evacuation early because the nearer we get to the front the less likelihood there is of having air available. Re control. I learned in the beginning that you could not get staff agreement on air evacuation. That applies to Algiers. I believe the responsibility for air should rest in the U. S. Air Force and adequate provision should be made now to insure definite provisions for evacuation of casualties by air upon call from ground surgeons in any of the theatres, etc.

"9. By making provisions now for a definite evacuation scheme to be used in the future.

"10. I don't believe communication between medical units was satisfactory in the CZ. Only communication was by telephone or messenger and very often medical units did not have telephone communication. I think radio in all field medical units would be an excellent idea.

"(G) 1. I don't think any particular trouble was found in actual tonnage for Medical Department supply. The lack of shipping caused considerable delay in arrival of personnel of medical units and also in the equipment of medical units. The Medical Department had to present bids for space in convoys the same as any other service. This usually resulted in a considerable increase in the strength of personnel arriving in the theater with no accompanying medical units. During the years 1942, 1943 and early half of 1944 in the Mediterranean Theater there were scarcely enough mobile and fixed beds in the theater to carry out the medical mission."*****

***** "3. Yes. Movement by echelon proved satisfactory only by gathering trucks from other sources to move a unit. Denial of transportation was an obstacle.

"4. I will have to qualify that statement. I think medical supply services should be made responsible for the distribution of blood if the source is from the U. S. However, if no arrangements have been previously made for a supply from the U. S. a unit or a subsection of a laboratory should be set up to provide blood for a unit. I feel very strongly that it is a supply item.

RESTRICTED



L. K. Pohl, Colonel, MC

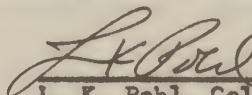
RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.
(Continued)

"5. From the standpoint of supply, I don't have anything in mind. We were always short of ambulances."*****

*****8. Under medium conditions of warfare the medical units were motile enough. However, they were not during periods of heavy combat. The greatest lack was transportation. Mobility should be increased. No."*****

***** "One of the main difficulties encountered by Army surgeons and army group surgeons was the transfer of medical units from one sector of the combat zone to another as an accompaniment to Divisions being transferred. In many instances as many as three divisions were transferred from one army sector to another without any medical units whatsoever. This places a great hardship on the Army surgeon into whose area the units are moved and leaves the army surgeon losing the divisions with extra medical units on his hands. A definite standing operating procedure should be developed which specifies what medical units are to accompany each division when transferred."*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE MEDITERRANEAN THEATER HISTORICAL SECTION - AFTAS

***** 0. "The efficiency of the Medical Detachment Dispensaries, Aviation, that accompanied the invasion troops was somewhat impaired by lack of equipment. It was later learned that their equipment had been sent to the United Kingdom where it was dismantled and used for stockage of depots by the Service of Supply. As a result these units did not receive their authorized equipment for approximately four months.

Organized Air Evacuation. The informal phase of air evacuation ended on 14 January 1943, when a formal plan for air evacuation of wounded in the Tunisian Campaign was adopted.

It was not until 10 March 1943, with the arrival of the 802d Medical Air Evacuation Transport Squadron in the theater, that air evacuation was under the direction of organized and especially trained personnel. This squadron was activated on 10 December 1942 and trained at the School of Air Evacuation, Bowman Field, Kentucky. Prior to the arrival of the 802d Medical Air Evacuation Transport Squadron, personnel for evacuation consisted of an emergency unit composed of thirty-five medical enlisted men from the 51st Troop Carrier Wing, under the command of the Surgeon, Headquarters and Headquarters Squadron, 51st Troop Carrier Wing. The base surgeons at the various airdromes supervised loading and unloading of the patients and effected the necessary coordination with Ground Force units. After the arrival of the 802d Medical Air Evacuation Transport Squadron, flight surgeons from this squadron were stationed at the various airdromes to supervise all air evacuation activities.

In the northern Tunisian sector, telephone, teletype, and radio communications were not dependable. Messages were sent back and forth by air courier.

It developed that air evacuation holding units located within 2 to 5 miles from an airdrome became a necessity. With these units able to accomodate from 200 to 700 patients, aircraft landing at these areas with supplies could pick up the patients without any delay occasioned by the failure of getting patients to the airdrome or a breakdown in communications. Moreover, patients would not be forced to travel long distances back to their hospitals when scheduled aircraft failed to arrive. The institution of this plan proved to be practical for all units concerned with air evacuation of patients.

With the period ending 23 May 1943, 17,216 patients were evacuated by air in the North African Theater. This included an estimated 887 patients evacuated prior to the arrival of the 802d Medical Air Evacuation Transport Squadron in the theater. ~~XXXXX XXXXXXXXXX~~

Summary of Air Evacuation Experience in the Tunisian Campaign. That air evacuation was practical was proved during the Tunisian Campaign, when 17,216 patients were evacuated by air without a single patient being lost on account of aircraft accidents. Also no injury was suffered by any of the flight nurses, enlisted medical attendants, or aircrews on any of the evacuation missions.

It is interesting to note that during the 129-day period in which organized evacuation was carried on only twelve days were lost because of bad weather. Although this interruption caused by bad weather did not materially hamper the over-all program, there was a 2-day period during engagements in

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE MEDITERRANEAN THEATER
HISTORICAL SECTION - AFTAS, Cont.

the Kasserine area, when all troop carrier planes were grounded, in which casualties were unusually heavy. This experience emphasizes the fact that air evacuation should not be depended upon as the sole means of evacuation but that other methods must be available to supplement it.

The primary objective of the planes used in air evacuation was the transportation of supplies and personnel to the forward areas, with casualties providing the load for the return trip. Therefore, it proved to be practical to plan air evacuation in conjunction with the supply-by-air program for the front areas.

Operations. The success of the initial landings and capture of airdromes in Sicily proved that the planning for the beginning of air evacuation was too conservative. Air evacuation was actually begun on D plus four from the Gela region.

In addition to 1233 patients evacuated from the Tunisian area to make room for the Sicilian casualties, 8976 casualties were evacuated by air from Sicily to North Africa.

Colonel R. E. Elvins, Surgeon, Twelfth Air Force, evaluated the experience of air evacuation in the Tunisian and the Sicilian operations in these words: "evacuation of patients by air is the most efficient, reliable and rapid method of evacuation of patients from forward areas." Although he pointed out that when planning was done in London for the invasion of North Africa, it was the official attitude of some of the top level medical planners that the Twelfth Air Force would not be required to evacuate patients by air "because ... this method (was) too uncertain, unreliable and hazardous for the evacuation of sick and wounded. Notwithstanding a lack of a definite plan of air evacuation for this invasion, all C-47 transports were equipped with litter racks in which both the American and British litters would fit.

With the establishment of the beachhead at Anzio and Nettuno on 22 January 1944, it was hoped to start air evacuation immediately.

It was not until the offensive from the beachhead got underway that it became possible and necessary to evacuate patients by air from the area. Evacuation by air actually started on 26 May 1944 and by the end of the month 2,024 soldiers had been moved to the Naples area.

Air Evacuation of casualties continued to follow the needs of the tactical situation during the remainder of the campaign in Italy.

That air evacuation in the Mediterranean Theater of Operations succeeded to an extent beyond the dreams of those who had faith in its practicability, to say nothing of those who lacked the ability and the imagination to appreciate the possibilities of this new military medical concept, is attested by the fact that during the course of the war in this theater, 212,285 patients were evacuated. During 1943, when air evacuation had to prove itself, so far as the use of it by the Allies in this war was concerned, and despite the obstacles confronted in instituting a departure in well-established patterns of procedure, there were 62,405 patients evacuated by air. In 1944, 125,878 patients were evacuated, and through June 1945, 24,002 patients were evacuated.*****

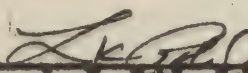
RESTRICTED

R. E. Elvins
R. E. Elvins, Colonel, MC

RESTRICTED


TRUE COPY EXTRACT (Letter, Captain Emmett D. Hightower (MC), U. S. Navy
dated 21 April 1948)

***** "(g) No medical service can function without adequate medical logistics. Based on experiences in the last war, I am greatly in favor of medical supply ships, rather than medical storehouses, in the advanced areas. The number of ships required would be determined by the size of the theatre of operations. During the last war it was almost impossible for medical storehouses to fill and ship requisitions on time because of the uncertainty of available bottoms. This at least held good in the South Pacific. Very frequently requisitions sent in by ships were not received for one year. Perishable supplies such as whole blood would obviously have to be supplied by Air Transport." *****


L. K. Fehl, Colonel, MC

TRUE COPY EXTRACT (Ltr Col R.P. Williams, MC, Surgeon dtd 16 Apr 48)

***** 6. "Medical logistics in military campaigns. Much of the logistical work can be performed by MCO officers but this, as in all departments of medical work, must be supervised by the Medical Corps. The new medical supply catalog is a big step forward. It should be followed up by unified procurement and then supply and distribution. Separate Army and Navy depots are no longer required."*****


L. K. Fehl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT FROM AIR EVALUATION BOARD SWPA REPORT NO. 35. THE MEDICAL SUPPORT OF AIR WARFARE IN THE SOUTH & SWPA FROM DECEMBER 7, 1941 to AUGUST 1945.

***** G. "Early methods of medical supply to the Air Forces were inadequate. The assignment of Medical Supply Platoons (AMN) to the Air Forces coupled with the use of transport planes to carry medical supplies to forward areas improved this service. However, the assignment of only three of the Medical Supply Platoons to the Air Forces out of the ten assigned to the theater, was not sufficient to care for Air Force needs.

Air evacuation in both theaters commenced as an emergency measure. Absolutely no organization was achieved during the early days of the war until Medical Air Evacuation Squadrons specifically designed for this purpose were assigned to these theaters. The full potentialities of the system of evacuation of patients by air was not achieved because of inadequate organization and coordination. The large-scale evacuation of patients by liaison-type planes from battle areas was extremely satisfactory. This system was under the complete control of the medical group attached to the Sixth Army and demonstrated the efficient results that could be obtained from centralized control of air evacuation. All types of patients were evacuated by air in emergencies in these theaters. However, the evacuation of certain types of patients by this means was found to be undesirable unless it was absolutely necessary. The Medical Air Evacuation Squadrons proved to be effectively organized and equipped to meet requirements in most respects. Theater policies did not permit the full utilization of air evacuation personnel, particularly nurses. Provisions for the rotation of flying personnel of air evacuation squadrons were inadequate throughout the course of the war."*****

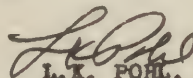
RECORDED
L. L. FOHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY (Ltr Dr. H.S. Hoffman, dtd 13 May 48)

***** G. "Medical Logistics in military campaigns in the Pacific, in my opinion, were "deluxe". Occasionally there was some delay in the matter of automatic re-shipments, but the initial supply list was adequate to carry organizations until further supplies and equipment arrived. Despite substantial losses in medical equipment and supplies incident to the raid on Roi and Namur on the 12th day ashore, adequate replacement was made promptly enough to prevent any real suffering."*****



L.K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Lt. Col. Grayson G. Garrison; D.O., USAF
Scott Air Force Base, Belleville, Ill., dated 26 April 1948)

***** "Dental equipment and supplies in the Middle East were very difficult to obtain from October 1942 to May 1943. Practically every group that arrived from the states during that period had no dental equipment. Each Group Dental Surgeon had the same story—he was told at the POB that his equipment was awaiting him at his destination. This resulted in many groups being without dental service until equipment and supplies could be obtained. This was done through the British Army and RAF who were very co-operative and willing to share what meager supplies and equipment they had and also by purchasing on the open market in Cairo, Egypt, at exorbitant prices, a number of essential items. Working with this inferior makeshift set-up during the above period played havoc with the moral of Group Dental Surgeons until U.S.A.M.D. Chest 60's finally arrived."

RECORDED

L. K. Fehl
L. K. Fehl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr M. C. Stayer, Major General, U. S. Army, Retired, 19 Apr 48)

**** (g) Medical logistics in military campaigns.

This has been one of the outstanding good things of the Medical Service. We have never heard any criticisms of the supplies furnished by the Medical Department. This was particularly true in the flow of materials to the various Theatres. However, I think when it comes to materials for the civilians of occupied territories, it would be better to have the advice of the Theatre Surgeons rather than that of people who had no idea what they were doing. There is a great deal of difference between writing a directive and operating. ****

A. F. POHL
Colonel, MC
REORDER

RESTRICTED

RESTRICTED

EXTRACT FROM INTERVIEW WITH BRIGADIER GENERAL SILAS B. HAYS, MC, USA
ON 11 MAY 1948 AT 2:35 P.M.

GENERAL HAYS: These questions are based on your theatres, I assume. My answers will be predicated on my experience in that theatre. I am fully cognizant of the fact that other theatres had entirely different problems which had to be solved in entirely different ways. The primary difference from a logistical standpoint between the various theatres, as I see it, was on their size, intervening distances between base commands and relative ease or difficulty of communication. The European Theatre was a closely coordinated area with no intervening water mass of any size, large numbers of troops, good transportation and good communications. Supply methods used in the Zone of the Interior required little change in that theatre to operate satisfactorily. At the other extreme would be the Pacific area with widely separated bases and large expanses of water, poor communications and water surface transportation in which each base commander had to be self-sufficient and in which each local commander had to have all facilities under his complete control. The Mediterranean theatre was probably in between these two extremes.

(G) Question 1. What was the prime failure in medical logistical fields in your theatre? Did lack of supply hamper the medical effort? Did the lack of shipping cause the difficulty? Was it staff or command decisions that proved the obstacle to accomplishing your plans? How can we correct that?

GENERAL HAYS: We had relatively little difficulty in the European Theater. We had shortage of a few items, none of which were important enough to affect operations. Our principal difficulty was in split shipments of hospitals arriving in the theatre so that hospital equipment had to be assembled within the theatre. Another difficulty was what I term the logistical paradox in that the smaller the item is the much more difficult it is to move sometimes. This, I would think, applies only to theatres utilizing rail transportation in which the G-4 and the Chief of Transportation is desirous of moving tonnage rather than necessary items.

ADMIRAL ANDERSON: Regarding split shipments. Do you have any suggestion about improvement?

GENERAL HAYS: Yes. We have developed a system whereby the Surgeon General or Chief Medical Officer is charged with the responsibility of assembling all hospital organizational equipment

RESTRICTED

RESTRICTED

EXTRACT FROM INTERVIEW WITH BRIGADIER GENERAL SILAS B. HAYS, MC, USA
ON 11 MAY 1948 AT 2:35 p.m. (Continued)

except motor vehicles, minimum essential equipment (MEE) and personnel equipment. This includes the equipment not only medical but also that of other technical services, of packing and marking this equipment for overseas shipment and preparing complete documentation. This has now been done twice on an experimental basis, once in the European Theatre of Operations following V-E Day in redeployment of troops and equipment to the Pacific and second, very recently in shipment of a few hospitals to Greece. There is now a proposed Department of Army Air Force Circular in process establishing this as accepted procedure.

Question 2. Did block ship loading prove adequate for your needs later in the war? Do you favor the block system of resupply? Did you find it feasible to change the components of the medical block satisfactorily in your experience?

GENERAL HAYS: My experience in the war was not extensive enough re block loading for me to make any intelligent comments. I would like to add something, however, to that and that concerns automatic supply. That automatic supply, while necessary and important, is only to be used in the early stages of establishing any base. That as soon as possible the base should requisition its supplies.

Question 3. Did lack of land transportation hamper the medical service during campaigns? Do you consider it essential that all medical field units have sufficient transportation to move all of its equipment, etc.? Did movement by echelon in units prove satisfactory?

GENERAL HAYS: The lack of land transportation did not hamper the medical service in my theatre, I think. No, I do not feel it is essential for all medical field units to have sufficient transportation. It depends on the amount of mobility expected of a unit in relation to the amount of equipment and supplies which it must carry. In regard to movement by echelon - yes.

Question 4. Should the supply of whole fresh blood be made a responsibility of our medical supply services? If not, who should handle it? Laboratory? Do you favor all supply of this item to come from the Zone of the Interior?

GENERAL HAYS: It is my opinion that all supply should not come from the Zone of the Interior, that indigent population should be bled and that service troops in the rear area should also furnish

RESTRICTED

RESTRICTED

EXTRACT FROM INTERVIEW WITH BRIGADIER GENERAL SILAS B. HAYS, MC, USA
ON 11 MAY 1948 AT 2:35 p.m. (Continued)

blood. I believe that the supply of whole fresh blood should be handled by a small specialized organization which handles nothing else. As to whose administrative control it is under, I consider it to be of relatively little importance. It may prove advantageous to establish these units handling whole blood at or near medical depots, or if conditions are different, it may prove advantageous to attach them to hospitals or laboratories. The collection and processing of blood within the theatre of course is a laboratory procedure, in fact, a rather highly specialized laboratory procedure requiring considerable equipment.

Question 6. What is your general impression of the medical supply effort and system during World War II? Where could it be improved? Did our supply units have sufficient personnel? Were they competent?

GENERAL HAYS: I think that our medical supply effort and system at the beginning of World War II were very bad. I think that we improved them all during the war and that in the last year or two of the war that they were efficient. Army-wise, the medical supply system in the later stages of the war was second to none, I think.

GENERAL MARTIN: Are we in a position at this time to resume campaigns in theatres of war with the same system and the same efficiency with which we ended World War II?

GENERAL HAYS: The answer is that we have still in the service a relatively large number of people who had a lot of experience during World War II. The new people that we have gotten in are being trained intensively in systems developed during World War II. We have on hand considerable amounts of supplies and equipment left over from World War II which has good and bad aspects -- bad because they are no longer new -- good because we have them. I think that I can feel confident that if we get into another war that we can make supplies available as rapidly or more rapidly than troops can be made available. The principal reasons for the supply situation being so bad at the beginning of the war Army-wise was: (1) We had been living in a peacetime penny-pinching period for twenty years in which the thinking of most people was oriented in the direction of economy above service. (2) We had a very small group of individuals who were trained in anything other than strictly station supply. (3) We had no equipment lists except those left from World War I. (4) We didn't know how to determine requirements, and (5) and least important, to my way of thinking, was the fact that

RESTRICTED

RESTRICTED

EXTRACT FROM INTERVIEW WITH BRIGADIER GENERAL SILAS B. HAYS, MC, USA
ON 11 MAY 1948 AT 2:35 p.m. (Continued)

while an industrial mobilization plan had been prepared, that the President did not see fit to put it into operation when war came.

GENERAL MARTIN: In your opinion, will atomic warfare, if used against the civilian centers in the United States, impose an overwhelming burden on the only available medical supply agencies that can be used in an emergency?

GENERAL HAYS: Of course, the answer to that is that one atomic bomb in one city wouldn't overwhelm us from a supply situation. Just how many atomic bombs, and injuring how many people -- I don't know. It would require several. I would assume that in that event that armed forces medical supplies would be made available immediately and that the armed forces would have to proceed to replace needed supplies. There is a very definite connection between civilian defense medically and the armed forces. I am not familiar at the present time as to how far plans along these lines have progressed. I do know that some plans are under way. In the event of atomic warfare affecting the United States all medical supplies and equipment both civilian and military would have to be made available. The Army now has nine medical depots in the United States, the Navy has five, the Veterans Administration has four, Public Health Service has one. I have a map showing location of these depots. In addition to that commercial wholesale stocks do exist throughout the country, generally concentrated in accordance with population. I think it is important that these plans for civilian defense for the medical care of possible civilian casualties processed as rapidly as is practicable and integrated completely with plans of the armed forces. To my mind, one of the big dangers is a tendency on the part of local people and by local people I mean everyone from the Mayor of a town to an Army Commander or a Navy District Commander who has a local area - there is a tendency to want to have a stockpile of supplies under their own control available for them in the case of emergency. There aren't enough supplies to build a stockpile for everybody and I think the plan which is evolved must provide for centralized control of stocks which are dispersed throughout the country.

GENERAL MARTIN: One reason for centralized control is rapid movement by air.

RESTRICTED

RESTRICTED

(g)

EXTRACT FROM INTERVIEW WITH BRIGADIER GENERAL SILAS B. HAYS, MC, USA
ON 11 MAY 1948 AT 2:35 p.m. (Continued)

GENERAL HAYS: Yes. We can get supplies in as fast as they can get the patients out of the contaminated area. Medical supplies are relatively small and easily transported by air. Even a complete hospital can be transported by air.

GENERAL MARTIN: The question is this. Is sufficient consideration being given in the development of lighter containers and equipment to the very obvious proven fact that the supply of light metals has always been critical in all previous war efforts and will not be allocated except on priorities to those services whose needs are greatest, for light metals?

GENERAL HAYS: Your point is well taken. The Air University at Randolph Field is working on the development of an airborne hospital and equipment to go in it. This work is being coordinated with the Army and Navy who are also working along the same lines. ***** The danger of selection of metals which will be required for aircraft production is being and will be given continuing consideration. Another pitfall which must be avoided is extreme ideas of lightening equipment and thereby getting away from commercially produced articles which are relatively easily procured. If many non-commercial items are developed, the result in delay of procurement will far overbalance any advantage gained.

Question 7. Did we waste medical supplies? How could this be prevented? Were any items in constant over supply?

GENERAL HAYS: Yes. Most of the wastage in medical supplies was the result of large supplies being on hand when the war ended or in the case of individual base theatres and bases when the war moved on to another location and the supplies were left behind. This could have been prevented by better computation of requirements and by a crystal ball which could have told us when the war was going to be over. Overall in the cost of the war this wastage was so insignificant as to be of no national consequence. Furthermore, many of these supplies have been diverted into civilian channels both in this country and in foreign countries and hence put to use, which, however, did not put money back in the taxpayers pocket. I don't think any items were in constant over supply.

. . . The meeting adjourned at 3:30 p.m. . . .

RESTRICTED

RECORDED
L. K. Pohl

447

L. K. Pohl, Colonel, MC

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

*****"(F) 8. I can't answer that one from a global standpoint. I think we came pretty close to having enough hospital ships in the Pacific from what I know. With a war going on, you can't always have everything just where you want it at the right time; but I don't know of any occasion—I am sure Admiral Anderson knows this better than I do—where our casualties suffered for lack of sufficient hospital ships. They suffered from lack of all sorts of other things, but I don't think a shortage of hospital ships was the answer. That's my personal opinion.

"Medical departments should certainly have control of evacuation, air and otherwise. I don't mean they have to command these units, but they certainly must have control over them so they can't be sabotaged and taken away just when we need them most. And that includes, in my opinion, returning cases to the Zone of Interior. From my personal experience we had little if any difficulty. We found excellent staff cooperation, and when the going was really tough and when evacuation was needed, it seemed to me from the highest command of the Pacific on down we got everything that they could possibly make available at the time, even furnishing fighter cover for our evacuation planes.

"As far as No. 9 is concerned, to assure air evacuation early in any future war, we must have early planning and we must see to it that the high command is aware of the importance, not wait until the plans are all made up and come in at the last minute and tell him we have forgotten something; we have to get it in early. And that goes back to one of my earlier statements that the medical people are part of the armed forces and they have to be not halfheartedly but wholeheartedly considered a part of the team at all times. They have to be in on the planning from the beginning.

"(F) 10. Communication between medical units are fairly satisfactory. It certainly would be enhanced with radio in all field medical units and I strongly recommend that all medical units down to and including collecting companies and divisions have radio communication of their own, so that they will not have to borrow from some signal officer.

"(G) 1. I have no specific comment on this question 1. All sorts of things happened and we ran short of things, and so did everybody else; not just the medical people. In my opinion it was just a question of a big job being done on a shoestring with everybody doing the best he could and not having quite enough to do the job the way we would like to see it done. Recommended correction, of course, is either better topside planning or maybe just better luck."

RECORDER

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:
Colonel Frederic S. Westervelt, MC, U.S.A. on 22 April 1948 at interview
with Subcommittee on the Employment of Military Medical Resources

"(G) 2. Block ship loading is fine under certain conditions. It's imperative in my opinion in the early stages of a base. A base that is going to be set up on captured land should have the advantage of block loading and automatic resupply for a reasonable length of time. This length of time, of course, depends upon the distance from the Zone of the Interior; it depends upon the agencies through which requisitions have to pass; and of course it always depends upon the initiative and the training of the people at the base in knowing what they need and how to get it.

"I think that block supply shipments should be kept to the minimum. It is not an economical way to supply. It's expensive, like everything else in war, of course, and should be discontinued at the earliest possible moment. Our experience was that we could gradually shorten the period of automatic supply as we were able to put in trained people to initiate supply on their own sooner than untrained people could have done.

"It is not easy to change the components of the medical block once you get supply people running down the line and furnishing block A and block B and block C. It is in my opinion or in my experience rather complicated to bust into these blocks and try to change them; when they have a lot of things made up, they would rather ship them the way they are, and it's another slow, complicated process.

"(G) 3. My opinion does not reflect a world-wide opinion. We were never operating in large land masses and therefore land transportation was relatively much more effective. By that I mean short hauls, short distances. With lack of some of the severe mountain terrain which was experienced in other theaters, our land transportation was relatively much more effective, I am sure, than it was in other theaters.

"I think it is advisable, maybe not essential, that all field medical units have sufficient transportation to move their equipment. It would certainly tend to keep the medical department on a mobile basis without recourse to aid from other agencies.

"I never saw any units moved by echelon and I am not qualified to comment on that.

"In my personal experience denial of additional transportation was a minor obstacle in planning, but it was never done unless it was absolutely necessary."

RECORDER*L. K. Pohl*

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic B. Westervelt, MC, U.S.A., on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

"(G) 4. I feel that supply of fresh blood should be handled by the supply services. Whereas the laboratory checks certainly might be indicated, the laboratory people are not a supply service. They are not set up to supply items and to move them and store them in any bulk. I feel that the medical supply people should handle the storage of and issue of fresh whole blood.

"I can't answer this part (b), but I favor all supply coming from the Zone of the Interior. I don't know how it happened in other theaters. In our case it did come from the Zone of Interior. It all came from the states, and even with the extreme distances involved the supply was exceedingly prompt. I don't believe we ever received blood more than six days from the time the blood was drawn even when we were on Okinawa, and in our particular situation it would have been entirely impracticable to use local source of supply.

"(G) 5. I can't answer question 5 in any specific detail. We were never in my opinion theater-wide short of anything. I may have forgotten something. I can't offhand think of anything in which we were short. Locally an item might be short and might have to be flown in from another base. This was done repeatedly, of course, in the case of whole blood. And as I remember a Line item in the case of mortar ammunition. It doesn't involve us here. We were never, to my knowledge, critically short of anything that affected the mortality rate or the immediate comfort of our wounded. We sometimes were down to where we had to see the next plane coming in, but we never actually ran out."*****

"(G) 9. In answer to the first part of No. 9—I will try to answer all these—we noticed a considerable improvement in the appearance of the wards in hospitals after the nurses arrived on the scene. I think we noticed an improvement in the morale of the patients. Our posts in combat were so overloaded and the patients moved through them so fast that the morale factor from the presence of nurses was a relatively insignificant matter; far less significant than it would have been in a hospital where the patients remained for a long period of time.

"For professional reasons, the Navy gets along without women in their forward hospitals and the Navy runs some pretty good hospitals. We don't operate the same way. If we did, if we filled our hospitals around male nursing and male technicians, then I think you would get along without the women perfectly well. For psychological reasons — I think they were a very terrible psychological factor. The men are either in a Stateside type of environment or they are at war, and when you put men in the battlefield, many of them, and then have a few women, or you have convalescent men, or you have staff people or people of any category in large numbers and a few women, I think the morale factor is very bad."

RECORDED
[Signature]

RESTRICTED

L. K. Pohl, Colonel - MC

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic P. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

"I think that everybody wishes it was his own family there, and I think they would probably be better off from a psychological standpoint if the women were kept out of the picture entirely. I am referring now to the combat areas, of course.

"Females very definitely hamper the movement of a unit. In our case their absence was almost crippling--in our cases at Saipan and Okinawa, and places of that kind, it was a very serious drawback because we were using units that were designed to operate with female nurses and then we didn't take the nurses in because of the fear of capture. That was the chief reason we didn't take them in. We didn't want the nurses to have any reasonable possibility of being captured by the Japanese. At Saipan the nurses never went in during battle. I believe they got there the day the flag went up, excuse me. At Okinawa we arbitrarily set a 30-day deadline in advance. This was just on guesswork. We actually permitted the nurses to come in, as I recall, at the end of about six weeks. In the meantime our hospitals, terribly overloaded as they were, were operating short the actual bodies of the nurses.

"If these hospitals had been designed to operate with male personnel, the efficiency would have been considerably greater. My personal recommendation is that we keep women out of the combat zone."*****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain W. D. Small, (MC), U. S. Navy
dated 5 May 1948)

***** "6.***In general I believe that medical department organizations in all the Services were notably superior in accomplishments as compared with non-medical branches.

7. With a few glaring exceptions, medical logistics in the Pacific during World War II were adequate. In this connection the following generalities are offered:

(a). Army medical officers who had been trained in staff and logistics duties were much better equipped for their work than comparable Navy medical officers whose knowledge had been acquired solely from experience. Navy officers should be similarly trained.

(b). It was extremely difficult for the medical department to secure its required share of the total insufficient ship tonnage in every Pacific operation up to the Iwo Jima campaign. The allotment of tonnage for this campaign was secured with relatively little wrangling. For the invasion of Okinawa adequate tonnage was available and we had room to spare for all required medical stores and equipment.

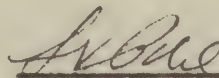
(c). During the summer and early fall of 1944, there was considerable misconception in BuMed of our requirements for supplies, based probably on a failure to recognize the vast distances in the Pacific in their relationship to the relatively greater quantity of supplies it took to keep the "pipe-line" filled. In late 1944, Rear Admiral K. G. Melhorn visited Pearl Harbor and, after evaluating the situation, felt that even more was required than we had requested. After this there were no further difficulties with Mat Div.

(d). One of the outstanding developments in logistics was the supply to combatant ships by tankers and storeships of previously packaged medical stores in empirical amounts and assortments. There was some criticism of the composition of those empirically packaged supplies. It would be obviously impossible to satisfy all needs in this manner. There is nothing wrong with the system and with further refinement, amplification and modification it should be employed again.

(e). The transportation by MATS in the Pacific of whole blood and its ready availability thru strategically located distribution centers and selected ships was an outstanding achievement. The system developed can be adapted for the rapid distribution of other perishable remedial agents as well.*****

452

RESTRICTED



L. K. Pahl, Colonel, MC

RESTRICTED

TRUE COPY TRACT OF INTERVIEW WITH COLONEL VIRGIL CORNELL, MC. /SA 30 APRIL 1948

***** 6. "Medical Logistics in Military Campaigns - All planned logistics are disrupted when bed capacity doubles upon landing; personnel and supplies are immediately inadequate. Depletion of the supply halves and even reduces to a smaller fraction, the necessary replacement period. The combat units to supply in forward depots are likewise lessened at the same time. The combat unit in forward depots should include all special items for the unit it is to supply. Replacement parts of special items should be stocked further forward. Many times some machine in a unit would be useless because the key part could only be furnished from the ZI.

I think that probably has been expanded upon before.

I believe the specialized training of medical supply officers in the lower echelons is needed. We had men trained in supply at higher levels, but almost anybody could become a supply officer, or had to become a supply officer, at the lower levels. At our depot in Italy there was a veterinary officer in charge.

Courier services should replace multiple use of vehicles by many units to one place. You know what I mean by that -- instead of having 15 or 20 units each send one little package by an ambulance, for instance, to our laboratory. We had one or two jeeps and the courier made the circle and picked up those items; so that one piece of equipment with us really reduced the gasoline, tire and vehicle consumption for many units. I think courier service can be expanded in many ways.

BRIGADIER GENERAL MARTIN: We would like to have your opinion as to whether the supply of whole fresh blood in theaters of operation should be made a matter of medical supply, the same as biologicals or deteriorator items?

COLONEL CORNELL: I might say that I attended a meeting in the Surgeon General's office just a week or two ago in which that was thoroughly discussed with a view to what units, what groups would be necessary for the procurement and handling of blood.

I think you know I have always been very strongly in favor of handling it not as an item of supply but rather as a deteriorating medical item that needed constant supervision. However, I think that opinion of mine was based mostly on my own experience where we were procuring blood in the forward areas.

It's presumed now that the blood supply will come from the ZI. That changes the picture. The present plan as agreed upon at that meeting was to add a team of an officer - not necessarily medical, but trained in the subject - and a group of 22 men with 14 refrigerated vehicles to the medical supply depot in the communications zone who would receive, store, and distribute the blood.

We studied the plan, the distribution points as it was set up in the ETO where the blood was received in Paris, redistributed to various points in the communications zone and from there forward to Army depots. We then felt that there might be another such team necessary to handle it at those forward supply points.

I suggested that that team be made up of sections so that it could be broken down and distributed in smaller groups at the smaller forward points.

I believe, with the supply coming from home and such a group designated for that purpose only within the supply depot, that it perhaps can best be handled

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COL. V. CORNELL, MC USA, 30 APRIL 1948

2. CONTINUED:

THAT way. However, we then went on and drew up a TO and TE for a unit which might function to supply blood to that communications zone depot if and when we couldn't get blood from home, because if we have a week's bad flying weather or are so located that flying can't be continuous, we might need to draw blood in the forward areas.

So we have conceived a team based on a 500-bottle a day supply, which is, incidentally, what was figured would be coming forward for so many men, to this depot from the interior. Now, to supply that by a forward team we would need one about two and one-half times as large as the provisional unit we had overseas, and we based it about on that. It would be a base unit with, I think, four bleeding teams, and figured about that they could supply about 500 a day at a forward area.

Now, the whole thing is there may be times when you are going to need that all of a sudden, and if that unit is not standing by, you might be unfortunate and not have enough, because at the same time you can't fly blood forward, you can't fly the wounded back, isn't that right?

These are the plans, and as far as I see then are perhaps the best we can make. We may again in some areas have to organize small provisional units. But there again you will be lucky if you have somebody around who has been doing blood-bank work and knows how to handle blood.

We did make this one other recommendation; that there be a professional officer in charge of blood procurement and distribution and supply in the theater headquarters, because you see the only man in charge of it in the depot is a non-medical man. We believe that a medical man with a knowledge of the professional use of blood should be there as an advisor and as a supervisor of blood supply throughout the theater who can say when, and lay down rules for the use and re-use and redistribution of blood.

That was the thing that I found so difficult to handle - was to use the blood to the best advantage; to get it back from the unit that wasn't using it, and getting it to a unit that could use it before our time was up.

Of course, another item which permits this plan to be of greater value than it would have been in the last war is the fact that we now have 21-day blood as against 7-day blood with which we were working in Italy. That makes this plan much more feasible than it would be with seven-day blood.

As to one or two other points which will have to be considered with regard to blood, the use of universal donor blood, "O" blood, as against the use of various types forward, I think the general consensus was that we should do that; that is, use "O" blood; that we need not type the donors; we could get a dog tag; that the eight to ten per cent error that would be found after the blood was drawn, those bloods could be withdrawn from the pool and turned over to base or general hospitals to be used according to type. Consequently, it would save a lot of time in preliminary checkup on the dog tag typing. Doubtless the dog tag typing will be a little better next time - I hope.

With regard to high titre "O" bloods, it was felt that we might add to all the blood going to the forward areas the Witelsky type A and B substances, thereby making all "O" bloods low titre. The ~~danger~~ danger in that is that if it were used in women of child-bearing age, we might create some havoc ~~definit~~ in the

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL CORNELL, MC USA 30 APRIL 1948:

9. CONTINUED:

wrong type individuals. We could not decide upon that definitely. I am still in favor of marking them high and low titre and using them accordingly.

With regard to RH factor, we feel that in emergency it can be disregarded in forward units for male sick and wounded. At the general hospital level where there may be female patients, then the RH factor should be considered and must be considered in those who have already received transfusions forward who may have been sensitized if they were basically RH negative. We had that just the other day, a case that should have been sensitized and had a reaction and then found out that somebody hadn't checked it, and so on.

But for the emergency use in the evacuation field hospitals, surgical hospitals, universal donor blood, I believe, marked with the titre instead of the addition of the substance, because we are not too sure as yet as to just what those substances do; there is undoubtedly always some excess of substance whenever it's used. We only use it now at Walter Reed in an emergency. If I have got a high-titre "O" negative and I want to give it to somebody, why then we will add the Witelsky substance if we haven't any other blood to use.

I think that covers most of the points, unless there are some questions.

REAR ADMIRAL ANDERSON: I would like to ask a little further about this particular subject, medical logistics in military campaigns. Do you have any comment about the adequacy of supply during the war in the areas with which you had experience? Were there acute shortages?

COLONEL CORNELL: Well, of course, Admiral, in a way, being with a specialized unit I did not meet it in the general supply program as much as I did shortages in some of our nonstandard items. The one difficulty we had was that when some special item was asked for to come from the SI, it took us years to hammer through the idea that that item should be marked for such and such a unit, and I think there was some time when some things should be marked for a specific outfit, whether it be a small unit or a large one, where that need is particularly for that unit. Otherwise, it comes in a supply depot, goes on the general shelves, and is only found when somebody walks through and sees it there, or someone wonders what this thing is and starts a query.

In general, I think the supply service was good. There were times when the dumps were left - when an Army moved and then they immediately sent in emergency requisitions for them, unless some of the stuff had been left in the supply dump back of them, you know what I mean. I think that was just a case at the time not having transportation to carry it; but I think, too, standard supplies were in general good. I think the most critical time is shortly after an invasion when you increase your capacity of your medical units that you have, thereby halving or even less, the length of time your supplies will last which you carried in, and at the same time the medical depots which come over with a theoretical three months' supply for you, their supply is halved, and if the hospitals are immediately supplied with the requisite amount, the supply depot theoretically has nothing left and it will be three months before they have any more. So that I feel the medical supply depots perhaps should carry a little longer supply to allow for that possible expansion.

RESTRICTED

L. K. POHL
L. K. POHL, COLONEL, MC

RESTRICTED

REPRODUCED FROM COMMENTS BY AIR FORCE MEDICAL DEPARTMENT OFFICERS, ANDREWS FIELD, TO COL. L.E. POHL, MC, AS PROVIDED INFORMALLY MAY 20, 1948.

***** 6. "The sutures of any type, as are other medical items, are subject to substitution. It is realized that any legal case arising from inferior products would be the Army's responsibility, but it is also much less expensive to purchase sutures, or medical items actually desired by the individual doctor for specific cases. In this respect the cost of processing local purchase orders under the consolidated system of supply, at many stations and bases today, in many instances exceeds the cost of the items purchased. Besides the expensive administrative overhead, a resultant delay due to processing through personnel who can not take action, to approve or disapprove, but make copies for "information files", is unavoidable.*****

RECORDED
L.E. POHL, COLONEL, MC

TRUE COPY EXTRACT OF INTERVIEW WITH BRIGADIER GENERAL JOSEPH E. EASTON, MC, USA (RETIRED) ON 3 May 1948.

***** 6. "BRIGADIER GENERAL EASTON: I think the medical supply thing, after the first bog down there - I guess that was due to improper planning that hadn't led up to it - we got all we needed; but we certainly have got to do something about the training of our own people, and also the civilian personnel when they come in, in the use of our medical supply tables and not have to get all the non-standard stuff - you would think we didn't have any. I have never seen the Navy, I imagine it's just the same as the Navy; if you couldn't practice medicine with that, then you shouldn't be practicing medicine. And yet right out of 10 people I have been practicing after they first came in for a long while, they asked for everything under the sun that wasn't in the table. They had to have it to practice medicine.

I believe that our present medical catalog - that anybody that knows how to practice medicine can practice, and when new stuff comes out, it's up to the higher supply echelon to get it and get it quickly and get it in. And I believe also, of course; if some young men or older men have something they want to try out for a little research of their own, they shouldn't be stopped.

REAR ADMIRAL ANDERSON: The Subcommittee on Medical Supply has set up a plan for joint operation of procurement and storage of medical supplies within the continental limits. What is your idea about extending a similar plan to theaters of operation in war? That is, I mean, joint supply.

BRIGADIER GENERAL EASTON: As I said before, you come in Admiral, supply is one of the things that you can merge a bit, and you should extend it just as far into the theaters as you can do it.

I think if you have a joint operation, Army-Navy-Air, you should have your group medical supply depots - what ever you want to call them - as far forward as you can get them. You ought to have them that way. *****

RECORDED
L.E. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRANSCRIPT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTT (MC) USN 4 May 48

***** Q. "Now as to the fleet, I have nothing but the highest admiration for the medical logistic service of the fleet. We had plenty of everything. When we ran out, in case we lost a ship or in case of a heavy loss, we were able to get supplies up by air and by ships and by cargo conveyances, as you know.

At no time at Okinawa were we short of medical supplies, even fresh blood. I saw blood given on Okinawa that was only 10 days old from California. I saw the date. No, we were not short. We were prepared, of course, for much more fighting than we actually got. Japan was on her knees before we realized it, I think. The supplies were there, plentiful and available.

REAR ADMIRAL ANDERSON: Was there a waste of medical supplies?

REAR ADMIRAL WILLCUTTS: I do not think so. There were undoubtedly supplies that were deteriorated from exposure, but not any great percentage. The packaging was such that we found that instead of a great unit originally planned for a battleship or field, it could be broken down. We knew that we needed the sulfa drugs and penicillin quickly, and they packaged that. We didn't take a whole specifications as we had to in peacetime when you drew your stuff ahead of time. We had to draw many, many items that we didn't need. But that was ironed out cleverly. I would say that the losses were very low.

REAR ADMIRAL ANDERSON: Are there any further questions? (None)


As to this next topic, medical logistics in military campaigns, do you have any suggestions about modifications of the system of supply?

REAR ADMIRAL WILLCUTTS: I think here we have something that unification of the services will improve. I do think medical logistics based upon procurement, joint basing, is a very excellent thing, and I agree with that thoroughly.

REAR ADMIRAL ANDERSON: Would you carry joint basing into the forward area?

REAR ADMIRAL WILLCUTTS: I would. After all drugs and surgical supplies, medical gear, is about alike. And when we treat our patients, as you all know, we treat them the same. A marine and a sailor went to the same place. Medical logistics has, in my opinion, been greatly improved and should be improved more by this unification.

REAR ADMIRAL ANDERSON: Any further questions on this point? (No)*****


L. K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA,
13 May 1948)

*****MAJOR GENERAL KENNER: "In that connection I was often, during this past war, impressed with the desirability of having an air medical service controlled by the theatre or chief surgeon. The air did a wonderful job for us, but the availability of planes for evacuation depended upon tactical requirements and not upon medical requirements. I believe, therefore, as I said, we should have an air medical service. That probably may be misunderstood. I mean air facilities controlled by the surgeon who has the overall responsibility of taking care of sick and wounded. I believe that had we had C-47s marked with red crosses and available for no other purpose than the carrying of medical personnel and medical supplies and equipment -- not available for any tactical purposes -- controlled by the chief surgeon, we would have been in a much better position, in the evacuation of Army installations and communication zone installation, than we were in this past war.

BRIGADIER GENERAL MARTIN: Do you consider that the airplane is now but another method of evacuating the sick and wounded and should therefore be placed in the same category as ambulances, hospital trains, hospital ships, and all those previously used conveyances? If so, is it not imperative that this newer method of transportation be similarly controlled by the surgeon of any unit in which there is this need for air evacuation?

MAJOR GENERAL KENNER: Absolutely. The only service that has not kept up with the modern air concepts has been the medical service. Tactically the air service has had nothing set up formally, except tactical and supply missions for tactical units.

It seems to me imperative that we should have an ambulance of the air just as much as we have an ambulance that rolls on wheels. I think it is imperative if we again envision the next war as departing tactically from previous concepts, because the distances involved in the next war will probably be much greater and your support will be much further away-- the bases -- than it was in this last war. Bear in mind that in World War II, in the invasion of the Continent of Europe, we had our base just a matter of 20 odd miles across the channel. In the next war our bases may be thousands of miles from the United States. They may not be as secure as the bases we had in this past war, and therefore we may consider that evacuation is going to be overextended. Air is the only means that I know of of getting your badly wounded back to your installations capable of rendering definitive care within the time that is going to be necessary to save lives or loss of limb."*****

*****MAJOR GENERAL KENNER: Going on to the next question -- medical logistics in military campaigns -- you are covering a lot of territory on that one.

RESTRICTED

RESTRICTED

I believe that we have not given enough study on our experience tables in establishing a better balance of medical supply, particularly in field units. Time and again you remarked, as I did, that there would be one item way in excess, piled up with nobody wanting it, as, for instance, cotton. This bird was carrying around a whole lot of stuff that nobody wanted, yet he would be short on an essential item that he would have to have.

I know that we started in Africa an experience table of supply. I don't know whether it has been continued. But certainly somebody must have made up experience tables. And if they are not made up, there are officers of the medical service who know what they should be.

I don't believe a field unit should carry one pound more than it has to carry. To stock up with a whole lot of stuff that comes up automatically, or not, is imposing an extra load on medical personnel, and to no purpose.

We had automatic supply. In so many days up would come a bunch of stuff. Well, a lot of it we didn't need. Yet some of the vital items were not coming up in such number. And in that connection, too, I am reminded that in some instances the communication zone had no medical depots within the communication zone. And up until December of 1944 there was no medical depot between Paris and the Army. That is a long line of communication.

As you know, a division requires 500 tons of supply daily. The French railroad train carried 500 tons. Now medical supplies very often would be included in a particular shipment. When the train arrived at a distributing point, nobody knew where the medical supplies were. The line went into their cars for their rations and Class V stuff, and the engineers went in for theirs; and it would sometimes be a week before the medical people would get in their supplies. So I think that our supply system in forward areas, in communication zones particularly, could be improved.

I may say those were just administrative faults. They probably were, but they shouldn't be repeated.

Now on coordination of supply requirements and standardization of medical items as between the Army, Navy and Air Force, with overall control exercised at the Defense level, brings us to previous remarks. It seems to me that common user items could be employed by the Navy as well as by the Army; and instead of having a special kind of forceps, we could all formalize or standardize our equipment and have interchangeable parts.

RESTRICTED

RESTRICTED

We made a mistake in this past war in our transportation. Here we had ambulances made by Ford, ambulances made by General Motors, ambulances made by other automobile concerns. The arms were confronted by the same situation. And instead of carrying spares for one make, and lacking interchangeability of parts, you had to carry a whole lot of extra equipment around.

It seems to me that we should adopt standard ambulances for the Services with interchangeability of parts.

Also, medical supply should be the command responsibility of the area or major unit commander for all elements of any of the defense forces.

REAR ADMIRAL ANDERSON: You have referred to automatic supply in the field. That is necessary early in the operation.

MAJOR GENERAL KENNER: Yes, but I think there should be some control over it, so that an agency that is shoving up too much stuff on automatic supply will be acquainted with that fact. I agree that we need automatic supply until such time, certainly, as we may establish the proper medical supply distribution.

BRIGADIER GENERAL MARTIN: In your experience, did deficient medical supply result in failure of the medical services, or reduced efficiency of the medical services of the field early in the war?

MAJOR GENERAL KENNER: No sir.

BRIGADIER GENERAL MARTIN: That is quite a point.

MAJOR GENERAL KENNER: At no time in my experience, either in Africa or later on in Europe, was there any deficiency in medical supply that adversely affected the medical service.

BRIGADIER GENERAL MARTIN: You have spoken of items that were at low levels. As the need arose the medical officers were able to use other items or substitute or get by?

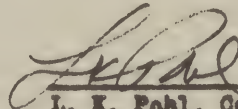
MAJOR GENERAL KENNER: Yes sir. In Africa we were in short supply on some items, critical items, but we didn't get so short that we couldn't carry out our mission.

BRIGADIER GENERAL MARTIN: Were the shortages due to difficulty in procurement?

RESTRICTED

RESTRICTED

MAJOR GENERAL KEMNER: Yes, but also to increased demand for those particular items. We ran into a lot of dysentery and diarrhea. Bismuth and sulphaguanadine were critical items in Africa." *****



L. K. Fohl, Colonel, MC

RESTRICTED

RESTRICTED

D-1h. HOSPITALIZATION AND EVACUATION POLICIES WITHIN THE COMBAT ZONE AND EVACUATION TO THE COMMUNICATIONS ZONE AND TO THE ZONE OF THE INTERIOR.

I. GENERAL

World War II presented a wide variance of situations to thoroughly test the doctrines of the Medical Departments regarding the evacuation and hospitalization of the sick and wounded in theaters of war. They proved sound. In the isolated instances where the process was not too satisfactory the lack of adequate facilities was responsible in most cases. Other failures were the result of lack of appreciation of the problem by new and often untrained medical staffs and command echelons. During the latter phases of the war much improvement was apparent in all echelons. This developed as the result of actual experience in the theaters of war which cannot be gained by individuals in the classroom during peace or war. Future war poses some possibilities that should be considered by our planners. While it is conceived that the atomic bomb will only be used on industrial and key targets in our homeland it is pertinent to consider the importance of our World War II Theater of Operation bases as targets for the bomb. Unless we can devise some other method of supplying ground forces engaged in a theater of war it is inevitable that large bases, containing hundreds of thousands of troops, must again be established at large ports of entry. Accepting the soundness of this premise, we can assume that the enemy will use the bomb early and often if necessary to destroy our vital overseas bases. Planning for this eventuality must take into consideration two important factors if an adequate medical service is to be furnished. The first of these is the location of hospitals. Henceforward it will court disaster to place base hospitalization facilities inside the effective zone of the atomic bomb. This means dispersion of medical facilities well out in the periphery of the port facilities. In turn, this concept will require the building of fixed hospitals where previously existing buildings in cities were used to the maximum. The second factor is the requirement for a large increase in the number of reserve beds authorized theaters of operation. If the medical service is to adequately cope with the casualties resulting from the atomic bombing of its overseas bases it is apparent that this need for additional beds is imperative. The argument that service troops serving a base will be dispersed to afford safety from atomic attack does not belie the fact that service troops must operate the bases from shipside and cannot do so without working in the danger zone. There is no escape from this fact if the base is to be operated. Japanese experience figures are the only ones available for planning. If followed, provisions must be made for hospital authorizations for overseas bases to care for one-half of the troop strength of any base. The urgency for

RESTRICTED

RESTRICTED

medical service facilities immediately following atomic attack cannot wholly or adequately be met by importing field type hospitalization units from other areas. The time element involved precludes any planning which waits until the event has happened before action ensues to meet its implications. Our previous experience in rendering battlefield medical care is insignificant and in no way comparable to the problems involved in caring for the number of casualties bound to result from a single atomic attack on masses of our troops. This possibility requires the immediate revision upward of our former figures used for calculating beds for Theaters of Operation. It inevitably must result in a greatly increased troop basis strength for the Medical Departments of the Services.

It is the consensus of all that the Navy and Air Force officers must be given staff status in command echelons in the future independent and distinct from the administrative and/or logistics sections of those staffs. This obtains in the Army as a rule and has proven sound. It has produced the desired freedom of action to discharge their responsibilities with dispatch and without interference.

There is a need for clarification of the rules of the Geneva Convention in the concepts of combat, staff and medical officers. Extreme difficulty was encountered during World War II in getting the armed forces transportation services to interpret the laws to enable the best use of protected transportation for the medical services. In view of our actions in using the atomic bomb against helpless civilians there is question as to our national attitude concerning international rules and agreements of the past for the protection of the helpless including the sick and wounded. This most important matter must be brought to a decision to permit of logical planning for the medical services in future wars. Action is indicated at once to force this decision. If the decision is that we are to continue to operate under current rules, steps should be taken at once to educate through proper means of publication all personnel of the armed forces on just what the laws permit us to do and not to do.

Because of the intensive attention being given to research and development by all the armed forces in the field of Arctic warfare this possibility has not been given detailed consideration in this report. It is believed that the current projects are comprehensive enough to indicate what special equipment and facilities will be needed to conduct military operations in the Arctic Zone.

RESTRICTED

RESTRICTED

II. ELEMENTS OF THE PROBLEM

1. Hospitalization

a. Combat Zone

Medical service in this area is wholly dependent on the type of conflict and the area involved. Field hospitalization as developed and used by the Army proved adequate in these areas when sufficient units were available to meet the needs. When they were not available for any reason, poor service resulted in the needless loss of lives and longer periods of morbidity and convalescence. Errors of the past should be corrected where possible in planning for the future. The basis for hospitalization well forward in this zone is sound. Its mission is to complete minor cases and to rapidly prepare long term cases for evacuation to facilities in the rear. The greatest medical failure in World War II occurred in this zone in that sufficient facilities were not made available for the definitive care of short term cases. The entire service was geared to efficiently handle the peak loads of wounded at the expense of the more important work of salvaging manpower well up forward. As a result, thousands and thousands of short term medical type cases were evacuated to communication zone installations where they remained for weeks and months in comfort and resisted efforts to return to the front. This unsound practice calls for a complete revamping of our estimates and requirements for mobile beds in forward areas based on the knowledge that in any campaign approximately 80% of all admissions have been medical in nature and that 90% of these have been salvagable in a fifteen day period. The system used for the care of the so-called "exhaustion" type of case in this area proved adequate and needs only minor refinement for the future. The recent development of the mobile surgical hospital of 60 bed capacity to replace the makeshift arrangement of World War II wherein platoons of field hospitals were utilized as surgical hospitals for selected major cases will solve one of the major problems in this zone.

In general, there was too much emphasis on evacuation in this zone rather than on sound medical and surgical care. The amphibious operations in the Pacific presented far different problems in this field than on the land mass of Europe. Often it was considered impossible or inadvisable for some reason to follow up the invading troops with adequate mobile field hospitalization units. The Okinawa campaign in the Pacific proved the essentiality of this

RESTRICTED

RESTRICTED

sound procedure which had been adopted as standard in the amphibious operations in the Mediterranean early in the war and later in the landings in Normandy. The permanent use of hospital ships and converted troop carriers or cargo vessels has been recommended by some as the ideal method of caring for the sick and wounded in amphibious operations. These floating medical vessels, unless greatly improved in number and special facilities for medical use are not considered ideal by many others. They do have their use in plans for small campaigns of expected short duration and they do provide extreme flexibility of medical means which is a very desirable factor in any situation. Major opinion prefers the use of field hospitalization ashore as soon as it is humanly possible to get it in. There is unanimity of opinion that most field hospital units should be similar in organization and equipment in the armed forces. There are some who favor the universal manning and provision of field hospitals by Army personnel for all land operations regardless of the identity or composition of the ground force. It has many advantages and should be given full consideration in future planning by the joint staff.

Mobile convalescent hospitals are a necessity in the type field Army medical service. The recent development of the 1500 bed type will improve the use of these important facilities in future land operations.

Large air force groups operating from fields in the combat zone should be provided with sufficient field hospitalization units if based at any great distance from ground force installations. The type field hospital was designed prior to World War II for use in these situations and proved wholly adequate in practice during World War II.

b. Communications Zone

Our medical doctrines governing hospitalization in the Communications Zone proved sound in World War II practice. Deviations from the ideal system which is always planned were often caused by unexpected tactical successes, especially in France. These fortunes of war will continue as in the past to test the flexibility of our plans in the future. Because of the fixed nature of the hospital facilities in this zone, flexibility to meet the unexpected can only be obtained by keeping units in reserve. This is often impossible without sacrificing needed beds and thereby

RESTRICTED

RESTRICTED

creating serious manpower losses by increased evacuation of short term cases to the Zone of Interior. The increased bed needs over World War II experience for this zone is covered under general discussion in Paragraph 1.

There has been general criticism of the practice of passing the sick and wounded through a series of hospitals in the Communications Zone before definitive care is reached. This is never desirable. It was forced by conditions beyond the control of the Medical Department in most instances. It can be obviated somewhat by better use of air evacuation, earlier triage and specialization of hospitals for type cases. However, until there is more certainty in the continuous availability of air evacuation, there will be need for advancing large hospitals in the Communication Zone as it advances behind the combat troops. Overlong periods in transit on vehicles or trains is not conducive to the best treatment of recent battle casualties. We must continue to move hospitals to the cases until our transport develops far beyond that of World War II efficiency.

It is generally agreed that station hospitals in this zone should not do surgery beyond their capabilities but that they can be used to relieve general hospitals of less serious cases. It is general knowledge that in war many hospitalized individuals develop "hospitalitis" which makes it exceedingly hard to return them to duty. Hospital commanders and their staffs often were not indoctrinated sufficiently on the importance of returning cases to duty at the earliest possible date.

There is universal agreement that convalescent centers are best established as part of each general hospital. This system allows a complete follow-up on each case by the same personnel which saves time and effort. From convalescent centers patients should be sent to reconditioning centers operated by the line. These centers require adequate medical staffs to advise on the physical condition of each individual to the end that harm is avoided as well as to insure speed in the reconditioning process. There is need for a SOP in this zone which can be rigidly carried out which specifies a uniform standard for transfer of cases to convalescent and reconditioning facilities. Too much leeway was given hospital commanders in this field during World War II and resulted in a needless loss of manpower.

RESTRICTED

RESTRICTED

War experience proved that the Communications Zone medical facilities were swamped with hordes of individuals who were passed on to them through medical channels but who were not sick physically and had proved useless as soldiers in combat areas. Obviously these individuals should have never been accepted for military service or at least for combat duty. There is need for specific administrative directives which will relieve the Medical Departments from the care of this type of individual promptly. It is a sheer wastage of medical personnel to permit their occupation of hospital beds. There has always been much wastage of time and facilities with confusion in the process of returning "duty" cases from hospitals to the placement depots in the Communications Zone. The responsibility in the Army for this process has been placed on the Personnel Section of the Area Commander's staff. The system has failed to work repeatedly, mostly because of lack of transportation and it has been recommended that a change be made in regulations and doctrine which will place the responsibility for the procedure on the commanding officers of Replacement Depots. This appears sound.

Detached Air Force commands in the Communications Zone must be given adequate hospital coverage. There is much demand by the Air Force for the assignment of general hospitals to them for the care of their sick and injured. The basis for this request rests in the assertion that aero medical trained officers can more efficiently supervise medical care to air crews and that administrative control of sick and injured air crew personnel is facilitated when they are concentrated in one hospital. Further, that there was a great loss of air crew personnel, especially in the Pacific, where the sick and wounded were hospitalized in many facilities. Later, this condition was improved by assigning an Air Force liaison group to each of the hospitals. It is believed by the Subcommittee that no harm would ensue if general hospitals, when actually demanded by the specific situation in a combat zone, were attached to Air Force commands for operational use only.

The construction of hospitals in the Communications Zone presented many trying problems, especially in the Pacific Theaters. For the most part the construction was accomplished by medical personnel which caused much wastage of specialized skills, but it was necessary if any hospitals were ever to be established. The Corps of Engineers in the Army who were responsible for this work failed to provide the means for the task. Navy construction of hospitals

RESTRICTED

RESTRICTED

ashore lagged even more than in the Army, indicating the same difficulties were encountered in the construction field. Because of necessity the construction in the Pacific was mostly of the Australian cowshed type. This type could be prefabricated and readily supplied. Later in the war stateside constructed prefabricated buildings were available and proved to be moderately valuable in the tropics. Had the campaigns extended to the temperate zone they would have been ideal.

Continuing study must be made in this field toward the developing of prefabricated structures that can be made available in ample numbers for Communications Zone needs. The locating of hospitals well outside the danger zone of large bases in future wars will surely demand the use of this type of construction for most fixed hospitalization.

The intricate maze of hospitals in ETO through which patients were passed from Germany to the United Kingdom is a good example of what the lack of facilities for rapidly building temporary hospital structures forward as the troops advance can produce. Many are of the opinion that by creating a Hospital Construction Division in the Corps of Engineers a forward step will be taken to eliminate the glaring deficiencies of World War II practice in the hospital construction field.

Holding hospitals are necessary in the Combat Zone. The Army has developed since World War II a new unit for this function so essential in operating an air evacuation system. There is divergence of opinion as to who should control these units - the Army Surgeon or the Surgeon of the Communication Zone. It appears logical to have the Communications Zone responsible for them on the basis that they are responsible for evacuation from Army service areas.

Efforts made by the Army ground forces to push development of ambulance means since World War II have been unsuccessful to date. On the sound premise that the medical services must operate ambulances on land, on the sea, and in the air, it is reasonable to demand that development in their physical features and use be accelerated by direction from top level authority. The Committee agrees unanimously that this is an essential need and must be done at once.

RESTRICTED

468

RESTRICTED

2. Evacuation Policies

a. General

The basis for the establishment of an evacuation policy in days within a Theater of Operations is sound. Planning for beds and evacuation needs in each medical echelon cannot be done without some basis for computation. Experience factors of World Wars I and II are reliable as guides for determining requirements for medical facilities in each of the successive medical echelons from front to rear. World War II proved our doctrines and methods sound in this field and there is no need for change except to readjust experience tables as necessary to the data accumulated during World War II.

The Army and Navy had different policies of evacuation in the Pacific. All agree that both services should have identical policies in the future, especially where joint use of medical facilities is to be generally adopted.

The purpose of establishing evacuation policies is to effect salvage of manpower as far forward as possible and to free forward units of long term cases as rapidly as possible to provide more beds for minor cases.

The policy will always be dependent on the number of beds available, the number of sick and wounded admitted and the amount of transport available for the movement of cases and the tactical situation in any given echelon of the medical service. Early in amphibious operations there can be no set evacuation policy.

b. In the Combat Zone

Practice has proven the advisability of establishing a ten to fourteen day policy for the combat zone. It can rarely be adhered to except in very static situations but does serve its purpose as a guide for planning medical facilities and the indoctrination of medical personnel in the process of sorting cases for evacuation. It must be subject to change on a minutes' notice to cope with tactical requirements. During quiet periods it was often increased to thirty days. The proper use and availability in the combat zone of sufficient convalescent hospitals will permit of a longer policy.

RESTRICTED

469

RESTRICTED

c. In the Communications Zone

The policy in these zones was established by the Surgeon Generals of the Services during World War II. It varied depending upon the medical facilities available in any theater and was from ninety to one hundred and eighty days in the various theaters. This system proved sound and requires no change in future plans of operation. Some suggest that the establishment of the policy be left to the Theater Surgeon rather than the Surgeon Generals. That is illogical as the Zone of Interior facilities must be geared on more definite and detailed plans which can only be made on reasonably certain estimates of the number of casualties to be returned from the theaters. It would seem feasible to compromise on an intermediate solution wherein the Theater Surgeon would recommend to the Surgeon Generals any changes in set policies as local conditions justified.

3. Evacuation in the Combat Zone

Developments in the use of air means during the recent war indicate consideration of fuller use of this means for the transportation of the sick and wounded. Tests in the suitability of the helicopter and various types of light aircraft are proving encouraging in this field. In certain areas the L-5 type of plane proved excellent for evacuation of single cases while in others it could not be used because of the rough terrain and weather conditions. There has been recently proposed by the Army Medical Department Board an air medical evacuating company equipped with twelve light planes for use in the Army Service area. It is proposed to keep these planes as a separate medical unit under direct medical control and to have them suitably marked with Red Cross insignia. This addition to the medical means available in the combat area should be considered a bonus and no reduction allowed in the recently authorized full complement of surface means of transport. Until terrain, weather, and enemy interference can be eliminated the use of air means in any combat zone must be viewed with extreme caution.

The standard system of evacuation contained in Army medical doctrine proved sound in war and needs no change for the future. In one theater the Army Corps was changed with the evacuation of division and corps medical installations to field Army units and they were given the necessary means to accomplish the task. This scheme proved to be excellent during a period of twenty months in combat and aided materially in the training of corps surgeons for higher medical command.

RESTRICTED

RESTRICTED

In amphibious operations especially in the Pacific it appears that every type of craft was used at one time or another in the evacuation process from shore to ship. Evidence, however, indicates that as experience was gained a better system for the orderly transport of patients to designated hospital ships developed. There is still much to be done in this field before the Medical Departments can approach the effectiveness developed for evacuation of ground forces engaged on land. Complaints of shore and sea medical officers were universal in condemning the lack of control not only of small craft ferrying casualties from beaches to ships but also the types of ships allotted them for the transport of cases to bases in the rear. The LSTH, although utilized in all theaters at one time or another seems to have been best used in the Normandy landings. The short haul involved in its operations made its use reasonable. For longer hauls it needs much improvement in its facilities. One of the major failures was the lack of control over the LSTHs by medical officers afloat on D-Day. In some cases the ships were directed by the line command on diversion missions and this resulted in the complete breakdown of the planned evacuation system on D-Day. Such employment defeated the planned use of these ships and must be corrected by stringent demands of the Medical Department of the Navy for control of the ships allotted to it in any task assigned.

It is possible that the Medical Service of the Navy should design and demand a special type water ambulance for off-shore evacuation of casualties. The British hospital carriers used in the Mediterranean were equipped with them and demonstrated their effectiveness on many occasions. Full control of these small craft by medical men with positive destinations was assured to the end that the useless ferrying and begging of larger craft to accept casualties did not happen.

Little criticism was elicited regarding the facilities of specially designed hospital ships. However, there were too few early in the war. This can be corrected by keeping those now in being in reserve during peace with provisions for early reconditioning in an emergency. It will always be too late if action to build or convert ships for this purpose is delayed until war comes. Several witnesses expressed the need for some type of fast ambulance ships for long water hauls of casualties. This should be considered in the survey of the whole problem of amphibious operations.

RESTRICTED

RESTRICTED

The further development in the use of air evacuation means to permit its early use in campaigns may well eliminate the need for faster long distance water transportation. Universal condemnation of the use of troop carriers for the reception and transport of casualties was forcibly brought out. Although the use of these ships was forced by necessity that fact constitutes a failure in implementing the medical planning for carrying out of its mission. This failure can only be corrected by stringent action on the proper level NOW to prevent the same error in future wars. It is unthinkable that the Medical Department of the Navy cannot secure the necessary personnel and equipment and full control over its use to carry out its responsibilities for the evacuation and care of casualties once afloat. The Navy has lagged far behind its sister services in this important field. There is definite evidence accumulated to show that naval line commanders and staffs have not been sufficiently indoctrinated in Medical Department functions and responsibilities, especially in amphibious operations. This can partially be corrected by proper presentation of its problems at the highest level and more training of selected medical officers for staff and command assignments in war at naval line and service schools.

The problem of amphibious medical service demands immediate survey by competent war experienced Army and Navy medical officers. Some workable system that will avoid the serious breakdowns in past efforts must be evolved. Considerable theoretical work on the solution of this problem has been started at the service schools of the Army and Navy. This experience should be utilized by the survey team in its task in reaching the answer to one of the poorest links in our medical services.

Evidence was elicited which indicated the need for better triage of cases ashore early in amphibious operations when air evacuation became available. It was largely because of lack of sufficient field hospitalization and qualified medical officer personnel ashore that the serious errors occurred. This brings out the importance of bringing sufficient and capable medical facilities in to shore immediately following the assault phases of an attack. No system of evacuation no matter how ideal offshore can obviate this oft-demonstrated and primary essential to good medical services.

4. Evacuation to the Communications Zone

Medical doctrine in the Army places responsibility for evacuation from the Combat Zone to the Communications Zone on the Communications Zone. This is sound and should be continued. In

RESTRICTED

RESTRICTED

many instances the Communications Zone did not have the transport facilities at its disposal for accomplishing the task and of necessity it fell to the lot of the Combat Zone Medical Service to do the job. As long as distances were short no hardship resulted. As distances increased the use of air means became imperative for good medical service. It was the breakdown in this form of evacuation which brought much criticism from the Combat Zone because of the damming back of its casualties which ensued. Although tactical needs for air transport means will always take precedence over its use for medical evacuation we cannot help but emphasize the dependence present concepts in the evacuation field play on this means of transport. If it is to be dependable and we believe it can be made reasonably so, there is need for development of a system to definitely provide the needs of the medical service. In one concept it is suggested that air transport by a process of evolution in development is replacing the slower means of the past; just the same as the motor ambulance replaced the horse-drawn in World War II. If such is accepted it is logical that the same control over air means as surface means should be vested in the Medical Departments of the armed forces. It may come when our aircraft building facilities are developed to the point where the air ambulance can be put into production without delaying or sacrificing combat type aircraft production. Until that time arrives and weather conditions are beaten to insure reasonable dependability, the reliance on ground means for transportation of the sick and wounded will have to continue. Extreme caution is demanded therefore in planning for the future to insure sufficient ground transport means for the movement of expected casualties.

Any system devised by the Communications Zone to effect its responsibilities should include means for rapid and constant communication between the medical echelons involved. Medical evacuation liaison personnel of the Communications Zone should form part of the staff of the Chief Surgeons in the Combat Zone area. By this means the requirements for the lift of patients in the Combat Zone can be readily translated into action directly and efficiently. There is much discussion as to who should furnish air means and how the operation of this means should be handled. Experience indicated that the presence of a suitably qualified Medical Department officer from the Medical Air Evacuation Squadron or from the Troop Carrier Command was essential on the staff of the Combat Zone Surgeons. Through his Air Force channels he was able to secure information as to the availability of lift in a reasonable manner.

RESTRICTED

RESTRICTED

The decision as to who is to furnish air lift for evacuation must be made for the Air Force under present limitations of air means. This decision should be demanded by the Surgeon Generals of the services if we are to devise a workable system using air means between the Combat and Communications Zone.

The use of hospital ships and air means for the evacuation of the sick and wounded from amphibious landing areas to intra-theater bases is comparable to the land phases in the evacuation process used between Combat and Communications Zone. In many instances temporary medical facilities afloat in the Pacific were overrated in capacity and insufficiently staffed to do major surgery. The results were obvious. It needs much study regarding its method of operation and the control of facilities. Because of the joint nature of most amphibious operations both the Army and Navy are involved in this phase of medical evacuation. Only joint service planning will solve the problems of the future to the satisfaction of all. The survey previously suggested should include this important phase of the medical service in its study and recommendations.

5. Evacuation to the Zone of Interior

Medical doctrine places the responsibility on the Zone of Interior for this phase of medical operation. Experience indicated the soundness of this doctrine and it needs no change for future wars. More autonomy by the Surgeon Generals in controlling the system of evacuation is indicated. World War II developed the use of air transport for this phase of medical service to the point where it must be adopted as a major means in the operation of the evacuation system. Recent developments in the carrying capacity of cargo aircraft presage more economical use of this means. It proved extremely dependable within the limits to which it was made available for medical use. Caution, however, is indicated in planning for the future in depending wholly on air means for this phase of medical service, especially early in war. Hospital ships must remain the backbone of the system until sufficient air means are provided for our needs. Aircraft production is the key to availability and until we are represented in production schedules for our needs it is imperative that we face reality if we are to accomplish our task. There is need for more study in the use and control of hospital ships used for Theater to Zone of Interior evacuation. The uncertainty of arrivals in Theaters proved a most distressing experience. Breakdowns which delayed their schedules were a major factor in their use. There has been enough experience accumulated in breakdowns to determine a definite mathematical factor for use in the overall scheduling

RESTRICTED

RESTRICTED

of trips. Time and time again the demands of theaters for medical evacuation could not be met and because of the local lack of beds this necessitated the use of scarce category cargo aircraft which had to be diverted from its primary purpose. The study indicated should determine not only the factors which led to the constant mechanical breakdowns of the ships but also the sufficiency of the ships we had to do the job. Methods of control by a central transportation agency of all hospital ships to guarantee the essential flexibility is demanded. The advisability of continuing past practice in assignment of some ships to Navy and some to Army control, more adequate communications including liaison systems, and the methods by which theater requirements can be processed are factors which must be considered.

III. CONCLUSIONS

The Committee concludes:

1. That medical doctrines and principles were sound in World War II experience.

That where sound planning was done and sufficient medical means were available, superior results were achieved.

That the reverse was true in certain instances.

2. That possibilities of future atomic war affecting the medical services in large overseas bases are pertinent fields for further study and planning.

That failure to appreciate these possibilities by provisions for adequate medical means may well wreck the reputation of our medical services.

3. That there is urgent need for indoctrination and training of naval officers to the end that their medical service is given the importance it demands in war planning especially in the field of amphibious warfare.

4. That clarification of our future status concerning the rules of the Geneva Convention and other international agreements for the protection of the helpless is necessary.

5. That field hospitalization in the Combat Zone as used by the Army was eminently successful.

RESTRICTED

RESTRICTED

That there was need for improvement in the technique of rendering medical service in amphibious operations.

That because of their joint nature in many instances more coordinated planning is indicated by the various medical services.

6. That the big failure of the medical service occurred in the Combat Zone because of insufficient attention and the lack of sufficient medical facilities for the definitive care of medical type cases.

That large wastage of critically needed combat troops resulted from this failure of the medical services.

7. That the provision of a new mobile surgical hospital by the Army for use in caring for non-transportables in forward combat areas will eliminate the need for World War II practice of improvisation in that field.

That this new unit will prove ideal for early use in future amphibious operations.

8. That in most instances the medical service in amphibious operations especially in the Pacific was not satisfactory.

That sufficient importance was not given this complex problem by line or medical staffs.

That intensive further study by experienced medical and line personnel is needed to iron out the difficulties encountered before anything specific can be accomplished to improve the character of medical service in this field.

That the supply of standard hospital ships was insufficient early during the war.

That the temporary use of troop carriers and cargo ships for medical purposes is unsound, dangerous and not up to the standard for medical service demanded by the American people for its combat soldiers.

9. That more convalescent facilities are needed in all echelons of the medical service.

That each general hospital should have its own convalescent section.

RESTRICTED

RESTRICTED

10. That the soundness of the doctrine which places the responsibility for evacuation of the next forward medical echelon on the next rearward echelon proved sound and demands no change.

That means to accomplish their respective missions must be authorized all medical echelons and be actually present in war.

11. That there was too much passing of the sick and wounded through successive hospitals in transit to definitive care in all theaters.

That better medical planning and more adequate and reliable direct evacuation means can prove the answer to avoiding this undesirable and wasteful practice in the future.

That this is a matter for local action rather than top level policy.

12. That there was universal wastage of medical means and combat manpower because of the lack of forceful medical leadership in every echelon in demanding the earlier return of patients in hospital to a duty status.

That proper indoctrination in this field for all medical officers was lacking.

That because of its extreme importance disciplinary measures should be considered as a means to enforce implementation of directives in that field.

13. That anxiety type cases proved a terrific burden on all hospitals in theaters of operations.

That more careful and scientific selection of individuals for combat duty offers some hope for alleviation of this medical wastage factor.

That administrative action is indicated to effect the prompt release from medical facilities of this type of individual.

14. That more and better consideration for hospitalization needs of Air Force troops in isolated regions is indicated.

That local arrangements between the involved surgeons may best serve the needs of each particular situation.

RESTRICTED

RESTRICTED

That this is usually a problem for local determination rather than one of top level control.

15. That the construction of hospitals by the Corps of Engineers of the Army during World War II in Theaters of Operation was entirely inadequate and that this contributed to serious wastage of medical manpower.

That definite action by the Surgeon General to correct this glaring deficiency must be taken before any future war if the medical services are not to suffer from the same lack of assistance.

That the suggestion that a special section in the Corps of Engineers be establishment for the development of this specialized field has merits and would prove no worse than the results experienced during the war.

That continuing research is indicated in developing some better type of prefabricated buildings for use in hospital facilities of Theaters of Operation.

That types developed so far are not suitable for universal use in the tropics, arctic and temperate zones.

16. That the recently developed holding hospitals are an important improvement in the process of evacuation.

That control of these facilities in the Combat Zone should rest with the Communications Zone which is charged with the responsibility for evacuation.

17. That the evacuation policies used in all areas during World War II proved sound and do not require any further study for reimplementation in the future.

18. That there is insufficient centralized effort being given to produce more efficient types of ambulances for land, sea and air use in evacuation.

That this must be sponsored as a medical problem at once if we are to improve the medical services of the future.

19. That the Army medical doctrine of the past proved sound in application in the Combat Zones during World War II and requires no change at present.

RESTRICTED

RESTRICTED

That air evacuation facilities in the Combat Zone should be provided by the assignment to Medical Department control of the Field Army Surgeon as a medical unit of not less than twelve helicopters or similar type light aircraft.

That the proposed air evacuation company should be adopted and be given a field trial.

20. That insufficient importance and attention was given by Naval line and medical personnel to the medical requirements of amphibious operations with the result that serious errors occurred in many instances.

That a well developed plan for the indoctrination of all Navy officers in medical logistics is a prime responsibility of the Surgeon General of the Navy.

21. That Army medical doctrine governing evacuation and hospitalization in the Communication Zone proved sound in practice.

That until more dependable air means are at hand adequate provisions for transporting the sick and wounded from the Combat Zones to the Communications Zone by surface means must continue to be provided in planning.

That when and if air means do become available to provide separate and primary use by the Medical Department that control over them must be vested solely in the Chief Surgeon involved.

22. That recent developments in the carrying capacity of cargo type aircraft indicate more economical means for Theater of Operation to Zone of Interior evacuation than during World War II.

23. That the system used for controlling hospital ships during World War II did not insure sufficient dependability to Theaters of Operation.

That this suggestion requires intensive study to elicit the direct causes for failure and recommendations for improvements in the future.

RESTRICTED

RESTRICTED

IV. RECOMMENDATIONS

The Committee recommends:

1. That further immediate and detailed studies by competent joint armed service medical personnel are mandatory in the following fields:

(a) The implications of atomic attacks on large overseas bases as it involved the medical services.

(b) The determination of our future status regarding the provisions of the Geneva Convention and allied international agreements for the protection of the helpless. This study to include a means for the indoctrination of all Armed Forces personnel as to that determined status.

(c) The development of sound doctrine and methods of procedure to cope with all of the medical aspects of amphibious warfare. This study to include covering the entire field of floating medical evacuation transportation.

(d) The development of an administrative policy which will more promptly relieve service hospitals in all rear areas of the masses of anxiety cases during war.

(e) The development of a better system for the control and use of hospital ships during war.

2. That action be taken by the Surgeon General of the Navy to enable the desired indoctrination of all Naval officers in the importance of the medical services in amphibious warfare.

3. That action be taken by the Surgeon Generals to sufficiently increase the number of medical facilities in the Combat Zone to permit of the salvage of medical type cases in these areas.

4. That staff action be taken by the Surgeon Generals to insure the improvement of hospital construction procedures by the Corps of Engineers in Theaters of Operation over World War II practices.

5. That necessary staff action be taken to set up a Joint Army, Navy and Air Force project for the development of better types of ambulances for land, sea and air medical use.

6. That more and better consideration for hospitalization needs of Air Force troops in isolated regions is indicated and should be provided.

RESTRICTED

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel O. F. McIlroy, MC, Air Force
dated 20 April 1948)

***** "h. Hospitalization and evacuation policies within the combat zone and evacuation to the communication zone and to the zone of interior are exceedingly dependent upon the type and locations of the military conflict. However, it is believed that a general policy of much greater utilization of airplane ambulances is desired. Medical facilities located anywhere near the front lines should be limited to emergency and first aid procedure, except in regard to the care of military personnel whose condition is such that their return to their organization within a short period of time is anticipated. The major portion of definitive surgery should be accomplished well beyond the front lines in the communication zone, thus enabling the establishment of larger and more permanent medical centers. By this, it is not implied that dispersing within such medical centers is not desirable. The general idea of longer range evacuation of selected casualties to the Zone of Interior at the earliest practicable date, should be carried further. In other words, the emphasis so far as possible should be placed upon carrying the patients by rapid means of transportation over longer distances to well organized and properly staffed hospitals rather than attempting to carry the hospital to the wounded." *****

481

RESTRICTED


L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT

(Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 22 April 1948)

***** (h) Hospitalization and evacuation policies in the first part of the war were totally inadequate for neuropsychiatric patients. There were, in spite of lessons from the last war, no plans for the care and treatment of one out of every four casualties, namely, the psychiatric patient. With makeshift efforts we developed such provision but these were far from what we should have had and should plan for in the event of another war. The Neuropsychiatry Consultants Division of the Surgeon General's Office has drawn up extensive plans for the treatment of combat psychiatric casualties and this plan should be quickly written into the regulations and implemented to the extent of setting up TO's, training programs and appropriate installations.*****

RECORDED

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr M. C. Stayer, Major General, U. S. Army, Retired, 19 Apr 48)

**** * (h) Hospitalization and evacuation policies within the combat zone, and evacuation to the communication zone and to the zone of the interior.

It has been my experience that this was done extremely well and I have no comment, except that I feel the hospitalization and evacuation were handled with expedition and good results. Air evacuation should be used to the utmost.****

RECORDED
L. K. POHL
Colonel, MC

TRUE EXTRACT COPY (Ltr Brig Gen Guy B. Demit, MC, Surgeon, dtd 16 Apr 48)

***** "H. Hospitalization and evacuation policies within the combat zone, and evacuation to the communication zone and to the zone of the interior - Here again it is essential to understand and appreciate what type of combat zone we are to have. The lines of communications so-called in the European Theatre consisted of properly constructed roads, railroads and air fields at convenient locations. The lines of communication in the Pacific Theatre were over vast expanses of ocean. The policies, tactics, and techniques of the medical service must be so flexible as to be rapidly readjusted to meet changing conditions, be they moral conditions, arctic conditions, or jungle conditions; transportation and lines of communication by land, sea or air." ****

RECORDED
L. K. POHL
Colonel, MC

TRUE EXTRACT COPY (Ltr Colonel Robert P. Williams, MC, dtd 16 Apr 48)

***** H. "Hospitalization and evacuation policies within the combat zone, and evacuation to the communication zone and to the zone of interior. These policies should be a part of every war plan and the result of unified staff action. Rotation policies between communication and combat zone units should be included.*****"

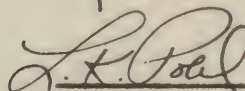
RECORDED
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert K. Simpson, USA (Ret.)
dated 1 May 1948)

***** "(h) Hospitalization and evacuation policies within the combat zone, and evacuation to the communication zone and to the zone of the interior. Within the combat zone, evacuation by aircraft certainly is most satisfactory, and it is my desire to place special emphasis on the liaison type of aircraft and the helicopter. In the communication zone and to the zone of the interior, the use of the larger cargo type of airplane altogether will depend upon the part of the world where the conflict may be. I am of the opinion that hospital ships can be utilized to an advantage as floating evacuation hospitals rather than as a means of transportation of sick and wounded. This was certainly true in the Southwest Pacific, and particularly in the Leyte campaign where general hospitals had to be hewn out of the jungle and mud. The policies adopted during World War II as to types of cases evacuated to the zone of the interior, etc., were sound and to the best of my knowledge and belief satisfactory. Psychoses should be evacuated to the zone of the interior as soon as possible. Extremely mobile surgical hospitals, with carefully selected trained personnel, should function as far forward as possible. The idea of employing trailers should be considered rather than tentage altogether. The use of tentage, in my opinion, should be abandoned; there is no comparison with the Quonset hut and pre-fabricated type of housing.*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Letter from Capt. Warwick T. Brown, (MC), USN
dated 20 April 1948)

***** "h. Hospitalization and evacuation policies within the combat zone, and evacuation to the communication zone and to the zone of the interior.

Based on experience in amphibious operations in the Pacific Area during World War II, many of the hospitalization and evacuation problems in this type of warfare would have been solved if more hospital ships had been available. The utilization of troop-carrying transports as hospital ships after they had discharged their troops was never entirely satisfactory. These ships were usually overloaded with casualties far beyond the capabilities of the medical staff and facilities aboard. Their primary purpose was transportation of troops, not the care of the wounded. Their utilization as hospital ships was complicated by the many factors related to the combat situation. Hospital ships on the other hand provide better facilities for the care of the sick and wounded. Some could remain in the area to care for the slightly wounded and thus return them to duty and prevent the enormous loss of manpower occasioned by the departure of the transports with men who could return to their organizations in a few days. During the war in the Pacific in shore to ship evacuation LST's designated as "Evacuation Control LST's" were used as a link between the shore and the ships. The LST's that were used in this capacity were also utilized to bring vehicles to the operation. After they had discharged their vehicles they were hastily cleaned up and utilized as LST (H), the "H" meaning hospital. They were the weakest links in the evacuation chain. If these ships can be assigned entirely to the Medical Department on a permanent basis, completely converted, and equipped as small Hospital Ships, they can be utilized successfully in amphibious warfare. They should be altered to provide clean, readily accessible operating, shock rooms and wards. They should have a medical staff adequate to care for the large number of casualties handled so that they may provide a standard of medical care comparable to that maintained in other sea and shore-based medical installations. There is need for better control of ambulance boats and amphibious vehicles which are utilized in shore to ship evacuation of casualties. There were many instances in the Pacific war when these casualty-carrying vehicles received the "brushoff" from transports and the crews of these ambulance boats were required to paddle their wounded as they did at Gallipoli in World War I. This needless confusion was due to a dual responsibility in the operation of these boats. The assignment and operation of boats, amphibious vehicles, and ships for the seaward evacuation of casualties is a command and line responsibility. The medical care all along the chain of evacuation is a Medical Corps responsibility.

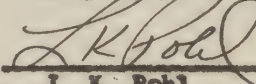
RESTRICTED

RESTRICTED

***** "H (Cont'd.)

The two are closely related. Some casualties can be safely moved; others must be retained where they are for necessary treatment. When and where casualties are to be moved must be decided by the Medical Officer. The dual responsibility complicated the task. It is believed this problem could be solved by having a line command group operating these boats under orders of the Commander of the operation. This task would also be greatly simplified by having more hospital ships to handle the seaboard casualty lift and by having a sufficient number stand in on D Day. **

RECORDER



L. K. Pohl
Colonel, U. S. Army

RESTRICTED

K...
RESTRICTED

TRUE COPY (Extract Ltr Albert T. Walker, Captain MC, USN, 26 April 1948)

**** "The matter of medical logistics in military campaigns, hospitalization and evacuation policies within the combat zone and within the zone of the interior, are all so intimately combined that they must be considered together. I feel that, to a large extent during the last war, too much emphasis was placed on casualty evacuation and not enough on adequate early, definitive surgical care in the combat zone. In the first place, our so-called mobile hospitals were not very mobile and during a rapidly advancing campaign, such as that in the Southwest Pacific and the Central Pacific, these Base Hospitals were left so far in the rear that much valuable shipping and aircraft were required to get the casualties to hospitals from the far beach. Long-term casualties were transported at too frequent intervals from one Base Hospital to another in succeeding steps away from the combat zone with no possibility of continuing care, and usually to the detriment of the patient. Long-term casualties should be evacuated directly to the mainland in high-speed ambulance ships or aircraft to minimize logistic support of Base Hospitals which are themselves too far behind the lines.

The nearest thing to adequate casualty care we were able to provide in the Southwest Pacific Area was by the use of properly staffed and equipped surgical teams on landing ships, such as converted LST's, which were set up to receive casualties within a few minutes of the original landing and to operate upon them when first received. These ships should be staffed not only with general surgeons but specialists in various surgical specialties and with blood banks with complete facilities for transfusions. In addition to these specially staffed and equipped landing craft for the immediate receipt of the casualties, there should be a number of high-speed evacuation ships, such as specially designed APA's, to augment aircraft on which casualties destined for long recovery periods or whose ultimate return to duty is not probable, can be evacuated directly to the zone of the interior. These ships must be constructed so that casualty spaces will be readily accessible. Our APH's during the last war were very poorly designed inasmuch as much of the troop space which should have been available for casualties was inaccessible to stretcher cases or ambulatory cripples.

The sequence of events for casualty care will then be as follows: fresh casualties are brought aboard specially equipped and staffed LST's or similar craft, are given early definitive surgical care including transfusions, short-term casualties whose return to duty is definite are kept aboard, long-term casualties are placed aboard the above-mentioned ambulance ships (APA's) to be taken directly back to the zone of the interior or an intermediate zone in which logistic problems can be solved locally. The short-term casualties will then be transferred upon the return of the casualty LST from the far beach to LST type hospital ships which have been specially designed as hospital ships (LSH's) and treated for ultimate return to duty. In this connection, we then have two types of landing ships performing entirely different functions. The converted LST's which take troops in on a landing which are fitted to carry surgical teams will receive and process casualties directly from the beach. When filled to capacity they retire, transfer their casualties to LSH's (the specially constructed hospital landing craft) and the long-term casualties directly to the ships designed as ambulance ships for transportation back directly to the zone of the interior. These ambulance ships must be properly staffed and provide

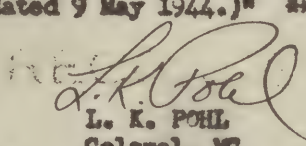
RESTRICTED

RESTRICTED

continuing care for the casualties during the trip home when such early, definitive surgery can be accomplished at the optimum time. It will be noted that no mention has been made of the Geneva protected hospital ships (AH). It is my feeling that the day of that ship has about vanished and that much better employment can be made of the converted LST and the LSH in the combat zone with ambulance ships for the long haul back to permanent hospital facilities. This plan will provide a completely integrated casualty program coordinated at Cabinet level, embracing Military, Naval and civilian cooperation.

As much as possible of Medical Department organizations and facilities should be kept afloat. This applies to medical storehouses as well as hospital facilities. Landing craft of the LST type are readily adaptable to both hospital ships and medical supply ships and inasmuch as they are afloat, they can be maintained wherever the need is greatest for them. They can move forward with task forces or remain in areas of fleet concentrations to be used as hospital ships and medical supply ships for the care of the normally sick and injured. There should be no Navy Base Hospitals overseas—all Navy Department facilities should be kept afloat with plenty of LSH's and LST type medical supply ships to handling all casualties and casualty care in the forward areas. In line with coordinated Military and Naval medical activities, it is felt that all shore based medical establishments should be under the cognizance of the Army and all such facilities afloat including all hospital ships be under ~~under the control of the Navy~~ under the control of the Navy. In this connection, it is of the utmost importance that the Fleet Staff be so organized that the Fleet Surgeon is placed on the same echelon as the other Department Heads such as the Operations, Intelligence, and Plans Officers and not in a subordinate position under a so-called Logistic Officer as most Fleet Staffs are now organized. Enclosure (A) is the organizational chart of the Seventh Fleet Staff showing the proper position for the Fleet Surgeon.

Plans for hospital LST's (LSH) were drawn and submitted to Naval Operations from Commander, Seventh Fleet in 1944. They were approved by the Bureau of Medicine and Surgery but were stopped at Naval Operations because of failure to realize that deep draft hospital ships did not provide the facilities for immediate casualty care which were inherent in the LST plan. (Refer to Commander, Seventh Amphibious Force Secret letter, Serial 00501, File FE 25/P6/L9-3 to Commander in Chief, U. S. Fleet, dated 9 May 1944.)# *****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

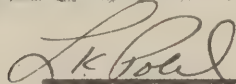
TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

**** "h. Hospitalization within the combat zone should be of as short duration as possible, only enough surgery and medicine practiced to prepare patients requiring definitive treatment for transfer to the communication zone and the zone of the interior, with a policy of short time illness and injuries being returned to combat without evacuation, where possible. Evacuation should be principally by air; other methods being used only where that mean is not possible. The use of helicopters for short hauls should be thoroughly developed." ****

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus, (MC) USN
dated 27 April 1948)

***** "(h) It is believed that the hospital and dispensary units as developed during World War II, in the form of 'G' components, provide excellent and adequate facilities for the general hospitalization of patients within the combat zone. Special medical outfits such as those furnished for the marines in amphibious operations and in forward positions were greatly improved during World War II and are considered to be entirely adequate. However, these outfits should be kept under constant revision and any new developments incorporated as indicated. In time of war it is believed that all hospital ships should be operated by the Navy but beyond this opinion it is felt that evacuation policies can best be commented on by someone more familiar with evacuation problems." *****

RECONDER



L. K. Pohl, Colonel, MC

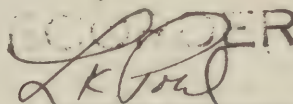
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M. J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

**** "(h) Hospitalisation and evacuation policies within the combat zone, and evacuation to the communication zone and to the zone of the interior.

Here again I think that these policies as I observed them to be carried out were sound. The wounded in accordance with their needs were brought to proper disposition in the shortest time practicable and possible. The use of aircraft in these proceedings was also most efficiently employed. Those personnel who required evacuation to communication zones or to the zone of the interior were sent back as soon as proper facilities were available. Therefore, discrepancies in this regard were bound to occur. The lightly wounded were in many instances soon to return to combat. The same is true of many of our sick. The physical means available to carry out these evacuations were several in type and in all probability would be those to be employed in a future conflict. They all served well! With an adequate number of evacuating aircraft, hospital ships, and hospital transports many of the early difficulties we in the Solace encountered could not occur. In the beginning of the war it seemed to me that we were evacuating a greater number of our combat personnel than was necessary from a strictly military viewpoint. Later on a tightening-up policy was employed, which in no instances according to my knowledge resulted in unfair or unjust treatment or neglect of the individual." ****


L. K. Pohl, Colonel, MC

L. K. Pohl, Colonel, MC

RESTRICTED

Pages 491-499 missing

RESTRICTED

TRUE COPY (Extract from Ltr Alfred W. Myer, Captain (MC), USN, 17 April '48)

***** (h) Hospitalization and evacuation policies within the combat zone and evacuation to the communication zone and to the zone of the interior.

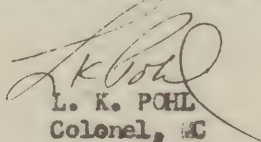
It is believed that hospitalization and evacuation policies for Naval personnel in the combatant and communication zones were adequate.

However, in future warfare, it is suggested that due consideration should be given to more extensive evacuation from the zone of communication to the zone of the interior. This infers the provision of minimal required hospitalization facilities in the communication zone and rapid evacuation of casualties, preferably by air.

Treatment in the combat zone should be limited to strictly emergency work. Good definitive care should be given in the communications zone.

It is not believed that retention of casualty non-effectives in the zone of communication for more than thirty days is practicable or feasible.

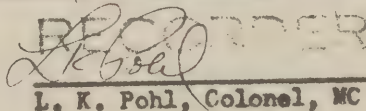
Further, consideration should be given the medical establishments in the communications zone based on probable types of warfare to be encountered. In possible total war, small well dispersed establishments are considered more practical. "


L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee, dated 18 April 1948)

***** "Hospitalization and evacuation policies within the combat zone and evacuation to the communication zone and to the zone of the interior.

"Again, the utilization of air transportation would change everything for the better--small planes and helicopters close up in the combat area, larger transports further back, casualties cared for with 2 bases 500 miles to the rear in really definitively equipped and staffed hospitals. Air evacuation also makes possible the immediate removal of most casualties to the zone of interior to be cared for in hospitals nearest their homes." *****


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Robert M. Gillett (MC) USN
dated 15 April 1948)

***** "Hospitalization and evacuation policies should remain
'fluid' and be left to Task Force and Area Commanders insofar as
practicable." *****

RECORDED

L. K. Pohl
L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Colonel John A. Rogers, MC, USA (Ret.)
dated 19 April 1948)

***** "H. Hospitalization and evacuation policies within the
combat zone and evacuation to the communication zone and to the zone
of the interior.

"It is believed that, in general, with the medical service well
established, a ten day period of evacuation is suitable within the
Army area. The 3000 bed Convalescent Hospital, or two 1500 bed Con-
valescent Hospitals, will provide the necessary facilities for the
care of such cases. Any patient needing more than ten days' hospi-
talization should be evacuated to the communication zone." *****

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr. Col. Harry G. Armstrong, MC, 16 April 1948)

**** "h. Hospitalization and Evacuation Policies Within the Combat Zone, and Evacuation to the Communication Zone and to the Zone of Interior.

(1) Defects:

- (a) Complete control over hospitals by Ground Forces.
- (b) Arbitrary standards of evacuation.
- (c) Failure to appreciate and use air evacuation of patients.

(2) Remedies:

- (a) Air Force have its proportionate share of hospital beds.
- (b) Air evacuation from combat zone of all possible patients.
- (c) Evacuation to the zone of the interior rather than establishment of advanced hospitals." ****

RECEIVED
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr W. H. Michael, Rear Admiral (MC), USN, Retired)

**** "Hospitalization in the combat zone in the 7th Fleet was and should be predicated on inability to do duty. The extent or distance of evacuation should be determined on the estimated length of the period of disability and the strategic situation. That is, it may be advisable to keep a patient at an advanced hospital who has a prospective disability of as long as 2 weeks, while operational prospects may dictate air or other forms of evacuation from advanced hospitals for patients who have a prospective disability of only 3 days. The same principle should obtain all along the lines of communication returning to duty those able to do duty and keeping or passing the others along depending on the prospective periods of disability and as directed by the staff medical officer based on his estimate of the situation. In overseas duty some criterion as to length of estimated period of disability should be established and all with a longer period should be sent to the United States.

"Definitive evacuation to the United States from the 7th Fleet was being abused when I reported, so that the fighting services were losing uselessly several thousand men a month - many entirely non-medical problems. That is, commanding officers used and misused the medical department to rid their units of all men who did not measure up to their standards of discipline and ability. Many of these men were finally demobilized with a psychiatric diagnosis.

"Another item I consider important: We found a most valuable means of evacuation in the Southwest Pacific was the L.S.T. equipped as an evacuation ship. About one out of six of the LST's used in an assault was converted into an evacuation ship as soon as it had sent its troops and transportation ashore. The details of the setup should be available in the archives of the 7th Fleet. This idea to put hospitalization at the shore with the assault group should still have it utility.

"I have had no experience on evacuation in the zone of the interior except evacuation to specialized hospitals from Long Beach. That system seemed satisfactory." ****

RECEIVED
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Ltr Capt H.E. Haring (MC) USN, dtd 17 Dec 47)

***** H. "This letter is prompted by the belief that the problems of Amphibious Medicine, and recommendations for improvement of our amphibious and field medical service are of sufficient importance to warrant their calling to the attention of the Surgeon General in this manner. The past two years have served to show that while some progress has been made in putting into effect the lessons learned in the war in the field, little has been done to correct certain basic premises that war experience proved to be erroneous. In an article for official Naval Medical History completed some nine months ago, I pointed out the fact that we in the field took care of approximately one hundred thousand battle casualties besides countless non-battle and disease casualties. The medical service of the forces afloat was called upon to further evacuate not only our casualties but many more from the Army as well. It appears to this officer that a medical service that is called upon in battle to assume such a burden should have more representation in time of peace in the Bureau and high commands in order that we may keep pace with new developments and maintain a high state of readiness. On my return to the States at the conclusion of the war in the Pacific, I visited the Bureau and was astounded at the complacency that existed regarding the efficiency of our field forces and off-shore evacuation facilities. I do not mean to imply that the medical care available was not up to the standard of other branches of the service, but it could have been so much better in some respects, I believe, if the recommendations which will be made later had been in effect before and during the war. A detailed account of my own observations as to the inadequacy of our amphibious and field medical service would take more space than is available in a letter. Much of it has been touched on in my article but there were many things that it was not thought advisable to include and they were only touched on in a general way. Actually, as late as Iwo Jima, our system of distribution of casualties was literally a hit or miss proposition and the caliber of the surgical treatment obtained is well brought out by the fact that fifteen out of sixteen belly cases dying of peritonitis at the 148th Army General Hospital on Saipan had been operated on aboard ship off Iwo and still had one or more unhealed perforations of the intestine. This is no recrimination of the personnel or their efforts. Admiral Lannings report of the off-shore evacuation there describes at some length the terrific problems that were encountered. This very honest report could well be written about several other operations in which I participated. Nor were the deficiencies of off-shore evacuation our only problem; inadequate equipment, untrained personnel and disregard of the basic needs for successful preventative medicine all made the maintenance of health and proper treatment of casualties a very difficult goal to attain. Lack of a definite doctrine originating from the Bureau as to the Medical Departments' role in amphibious warfare. Such doctrine, emanating from high authority could not have so lightly been disregarded as it frequently was when coming from individual staff officers. An example of this is the discouraging lack of LST's available to the Medical Department as LSTH's. The use of this type of evacuation at

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Ltr Capt E.R. Hering (MC) USN, dtd 17 Dec 47) CONTINUED:

night where definitive care is available, is the absolute key to successful amphibious medical service. Not until Okinawa were we allotted sufficient LSPH's to properly carry out our mission. Present doctrine (USF 6) defines their use but gives too much leeway to individual task force commanders for their employment. Another error in basic doctrine is that an APA can take care of one-hundred and fifty serious casualties and three hundred and twenty-five ambulatory casualties. The meager facilities in personnel and equipment aboard an APA make this an impossibility, yet doctrine of this sort was written into medical plans throughout the war.*****

L. X. Pohl
L.X. POHL, Colonel, MC

RECORDED

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Bascom L. Wilson, Colonel, MC, Air Forces, 21 April 1948)

****Reference par 3(h) "Hospitalization and evacuation policies within the combat zone, and evacuation to the communication zone and to the zone of the interior," it is felt that in the Combat Zone, when a large proportion of the combat personnel is composed of Air Force personnel, a certain number of General Hospitals, according to the proportionate number of Air Force personnel present and casualties anticipated, should be assigned to the Air Forces, in order to concentrate that personnel, for better personnel accounting and for closer supervision of Air Crew personnel by Medical Officers trained in Aviation Medicine. This is a considerable morale factor with Air Crew personnel. As to whether this be an Army Hospital or Air Force Hospital makes little difference except that it should be under the jurisdiction of the major Air Force of the Combat area concerned. During the early days in the Pacific Area, great difficulty was experienced in keeping track of Air Force casualties, they being transferred from one hospital to another, to finally where many could not be located, resulting in loss of Air Force personnel for long periods of time, and often unnecessarily so. If the Air Force had its own assigned General Hospitals in the combat area, improved morale, closer observation of Air Crew personnel with decrease in time lost, with no loss in their efficient Medical and Surgical treatment would ensue.

Later on, in the Pacific Area, Medical Liaison Officers were assigned to each General Hospital mainly for the purpose of assisting hospital personnel in Aviation Medical problems arising; keeping track of Air Force personnel; and assisting individual Air Force personnel in their individual problems. This service was considerably expanded as time went on.

Reference the evacuation policies within the Combat Zone, considerable difficulty and confusion was experienced when the first Air Evacuation Unit arrived in the Theatre. It was assumed by the Air Force Command that this unit would function under its command, however, it was the decision of the Theatre Commander that inasmuch as the Ground Forces were charged with all evacuation services in the Theatre, the Air evacuation would be assigned to, and function under them, and this was done. This was a great disappointment and quite a morale buster to the Unit concerned. After trying out this arrangement for a few weeks, it was readily apparent to all concerned, that in order for the evacuation unit to operate smoothly and efficiently, it would have to be assigned and operated under the Command of the Air Forces. This was finally agreed to and the change was made. This unit under Air Force command, operated smoothly and efficiently, and made a great record for itself. Succeeding Air Evacuation Units were assigned to the Air Force without questions, and operated efficiently under its command.

Such command jurisdiction of units arriving overseas should have been decided long before and there should have been no question as to jurisdiction involved. While this is only one small isolated instance, if this were multiplied many times, which no doubt it was, it could cause a great deal of discontent, confusion, loss of morale and loss of efficiency."****

RECEIVED
L. K. POHL
Colonel, MC
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral A. H. Dearing (MC) USN
dated 26 April 1948)

***** "(h) Hospitalization and evacuation policies within the combat zone, and evacuation to the communication zone and to the zone of the interior.

"In the South Pacific area there was a lack of unified policy between the services regarding evacuation. The Army forces set up a standard that a man would require at least six months of hospitalization before he would be evacuated to the zone of the interior. This was by order of the Surgeon General. The prevailing conditions of hospitalization both for the Army and the Navy made a 90 day evacuation policy more desirable. It is believed that the policy regarding the length of time a man will require for hospitalization before he is evacuated to the zone of the interior should be left to the judgment of the Commander of the area who is familiar with all conditions therein rather than be arbitrarily decided in Washington."*****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Ltr Capt. E.P. Kunkel (MC), USN, dtd 21 April 1948)

***** "H. Our evacuation hospitals, during the last war, for the greater part, did an excellent job. With the distance that can now be covered in a short period of time and the number of patients that can be evacuated by air, only permanent hospitals should be constructed, well staffed and well equipped, far behind the front lines. Sheet metal buildings of the quonset huts type proved to be not mobile, and once they are set up, no attempt should be made to move them, at least not to a forward area. In a forward area, no second-hand buildings or equipment should be used. I believe that, depending on the climate in the operation area, lumber or tents, if available in sufficient quantities would afford the best material for construction of hospitals and barracks. Military hospitals in forward areas should be planned and staffed by armed forces personnel with no distinction made among patients as to whether they are Army or Navy. There should be no overlapping so far as hospitals are concerned, and all hospitals should be uniform."*****

L. K. Pohl

L. K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Lewis T. Dergan, (MC) USN)

***** "(h) Hospitalization and evacuation policies within the combat zone and evacuation to the communication zone and to the zone of the interior.

"All hospitalization ashore should be accomplished in very mobile type units with a short hospitalization policy not to exceed thirty days. The Naval Hospitals during the last war were not mobile in anything except name, they took too long to construct and were too elaborate in type. In both the New Guinea and Phillipine campaigns it was necessary for the Navy to utilize Army Hospital beds for protracted periods until Naval Hospitals could be erected. After the Leyte landing some Army Hospitals were receiving patients 48 hours after the first landings, it was over three months before the Navy had any hospital facilities in the same area.

"All cases being evacuated should be screened by an Officer equipped with the necessary medical knowledge and authority to reject cases of a trivial nature or those whose recovery could be anticipated within thirty days. Several times at Leyte Naval Hospital ships were offered to Army hospitals to evacuate their cases; from 50-75% of the cases loaded were of such a minor nature that the men should not have been on the sick list.

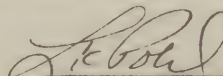
"Suggested Remedies

"(1) All hospitalization ashore should be in joint Army-Navy hospital, preferable under a jurisdiction of Army Medical Officers (Marine units are excepted as they offer a separate problem).

"(2) Evacuation from forward areas should be by air whenever that is possible. When other facilities are needed fast ambulance ships should be used; these should be non-Geneva convention in type as protection afforded by its provisions are becoming more and more theoretical.

"(3) Malingerers and cases of a trivial nature should be screened out and retained in the combat area.

"(4) Present day hospital ships could be dispensed with. Each combatant ship should be able to treat the majority of its casualties. In the event of a major disaster, a fast ambulance ship could clear the casualties." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED**TRUE COPY EXTRACT**(Letter, Captain O. B. Morrison, Jr., MC, USN
dated 23 April 1948)

***** "h. Hospitalization and evacuation policies within the combat zone and evacuation to the communication zone and to the zone of the interior.

Many factors influence the hospitalization and evacuation policies within the combat zone, such as numbers of casualties, available hospital beds, troop replacements, etc. As a general rule a 10 to 14-day evacuation policy in the combat area and a 30-day evacuation policy for the communication zone will prove most feasible. It is of the utmost importance that alternate methods of casualty evacuation be available and that personnel be thoroughly trained in all methods. Full use should always be made of air evacuation as this method is possible even to remove wounded from isolated front line positions. Ambulance pools should be used rather than the dispersal of ambulances among units that might not need them.

A convalescent or rest camp should be set up in each combat area and all combat fatigue cases sent there rather than evacuated from the area. It was found that about 85% were actually physical exhaustion and could be restored to combat units in four to five days after a good rest." *****

RECORDED
L. K. Pohl

L. K. Pohl, Colonel, MC**RESTRICTED**

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel P. A. Blesse, MC, USA, dated 19 April 1948)

"****8. Hospitalization and evacuation policies within the combat zone, and evacuation to the communication zone and to the zone of interior.

"a. Hospital and evacuation policies within the combat zone must be flexible.

"b. They must be changed constantly to meet the requirements of the military situation.

"c. The old established policies were proven to be sound in the last war.

"d. It is usually impractical to announce an evacuation policy within the army area, by number of days, as is done for theater evacuation.

"e. Evacuation of patients from Evacuation Hospitals should be a responsibility of the field army. They must be transported to air fields, rail-heads or Ports and if these are located within the Army area, the holding units established for their temporary care at these points should be under Army control. The communication zone medical service should be responsible for their transportation from the holding units in the Army area.

"f. Units must be carefully supervised to avoid unnecessary delay in the evacuation of casualties that should be evacuated and surgical procedures which are not in accordance with the mission of the unit.

"g. Frequent and unnecessary transfers of patients from one fixed hospital to another, should be avoided. This was a frequent source of criticism. It is impossible to provide the best facilities for all types of surgery in all fixed hospitals. It is advantageous, therefore, to carefully survey their capabilities with the aid of the consultants, and to designate certain installations for specified types of surgery. The station hospital cannot be provided with the type of specialist found in general hospitals and they should not be authorized to attempt work beyond their capabilities. However, they should be capable of relieving general hospitals of cases not requiring such specialized talent.

"h. There was a tendency to permit patients to remain in hospital long after they were fit for duty, or for transfer to convalescent establishments or reconditioning units. This seemed to be due to a lack of hospital

REC-111
L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT - Continued - Colonel F. A. Blesse, MC, USA

commanders and chiefs of services to appreciate the importance of the release of this man-power for military requirements. In many instances patients were held in hospital until considered fit for full duty rather than to transfer them to convalescent areas or to reconditioning centers.

"A standard procedure should be adopted and published to insure proper training and uniformity. Patients requiring no further hospital treatment should be, at the proper time, transferred to convalescent centers or to reconditioning centers.

"Convalescent centers should be established as a part of each large fixed hospital. These cases are not ready for reconditioning centers and remain under the general supervision of the hospital service where primarily treated. These cases are those convalescing and should remain on that status until ready for reconditioning.

"Reconditioning centers should be under combat experienced line officers. There should be sufficient medical personnel on the staff to insure proper medical supervision but discipline and military training must be emphasized during this period. Reconditioning and combat indoctrination are the objectives of such centers, and this cannot be accomplished if those sent to such centers are still convalescing.

"i. Patients returned to duty by hospitals were frequently unable to obtain transportation back to their units or replacement centers. It is important that such troops return to their own units and larger units often provided such transportation for their own. There were various trial arrangements to overcome this, but it is believed that replacement centers should be given this responsibility and the means with which to accomplish it.

"j. Evacuation of casualties in the forward areas is one of our major problems. In every war the defender will seek high ground and mountainous terrain. In Italy and Northern Tunisia short carries with six and eight litter bearers for each case were frequent. This is hard on the patient and a drain on our man-power. In these areas it was always possible to find small areas where a helicopter could have solved the problem. Other types of planes require landing fields which are not available except where vehicles usually can be used anyway. Therefore, helicopters should be assigned to the Combat Divisions as a part of their ambulance service. Ambulances are used on the ground, in the air or on the water, and each has the same mission, the transportation of

RECORDED

L.K. Pohl

RESTRICTED

L.K. Pohl, Colonel, MC

RESTRICTED

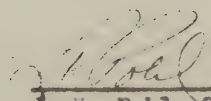
TRUE COPY EXTRACT - Continued - Colonel F. A. Blesse, MC, USA

patients. Every effort has been made to develop this project without success. It is recommended that a policy be established to provide these three types of ambulances for transportation of casualties and that development be accelerated by directions from top level.

"k. Failure to provide the required number of hospital ships until late in the last war caused considerable difficulty. The evacuation of casualties by ships not remarked and registered as hospital ships is dangerous and open to criticism and yet this was frequently resorted to. This should be a part of a preparedness program.

"l. The Rules of the Geneva Convention are not understood and are constantly misinterpreted. Their application should be studied, outlined, and published. Personnel, equipment and supplies were transported on British hospital ships but for some time at least, could not be moved on our own. This was due to our interpretation that this was a violation of the rules.****"

RESTRICTED


A. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain H. D. Templeton, MC, USN
dated 23 April 1948)

******* (H) HOSPITALIZATION AND EVACUATION POLICIES WITHIN THE COMBAT
ZONE AND EVACUATION TO THE COMMUNICATION ZONE AND TO THE
ZONE OF INTERIOR.**

On no occasion during hostilities in the Pacific in which the Navy and Marines played an important role was there a lack of adequate hospitalization in the combat zone. Probably the greatest single factor which contributed most to the morale of the wounded man was the realization that he would be evacuated to the communication zone as speedily as possible. This evacuation policy may have in some instances resulted in the evacuation of some wounded that might have recovered equally as well within the combat zone. It is believed, however, that such were rare instances, and our hospital ships, hospital ship auxiliaries and personnel transports were most effective in reducing the morbidity rate through early evacuation and supportive medical and surgical care enroute. The zone of communication was well prepared to take over the care and treatment of the evacuees and prepare them for further evacuation to the zone of interior.

The general policy of evacuating all wounded during the early days of an assault was a most excellent one and relieved the field and evacuation hospitals of a heavy burden. With the successful progress of the campaign, it was feasible to hold battle casualties for a longer period of time, and a fair percentage of such cases were successfully treated and returned to combat duties as hospital facilities became better established."


L. K. Pohl, Colonel, MC

513

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain W. C. Eaty, Jr., (MC), USN
dated 19 April 1948)

***** "The maintenance in ready reserve of an adequate number of Hospital Ships that can be put into commission soon after the outbreak of hostilities. Hospital ships have no other mission than the care of casualties. They can receive casualties directly from the beachhead. This eliminates one stage in the seaward evacuation chain along with the dangerous shock incident to repeated casualty handling and the delay in treatment which often results from the uncertainties of destination and reception of the ambulance boats."*****

TRUE COPY EXTRACT (Letter, Brig. Gen. Robert C. McDonald, MC, USA, (Ret.)
dated 15 April 1948)

***** "(h) Hospitalization and Evacuation Policies within the Combat Zone, and evacuation to the Communications Zone and to the Zone of the Interior.

"(1) Comment and Suggestions: Hospitalization in the Combat Zone should be in mobile medical units and should be of short duration. Patients requiring over 3 days' hospital care should be evacuated from divisional and corps units to Army units. Those requiring more than 2 weeks' care should ordinarily be evacuated to Communications Zone hospitals. Seriously ill and wounded patients should be transferred from the Combat Zone as soon as transportable. Except in theaters remote from the ZI all patients requiring 90 days or more of hospitalization should be evacuated to the Zone of the Interior." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT FROM AIR EVALUATION BOARD SWPA REPORT NO. 35. THE MEDICAL SUPPORT OF AIR WARFARE IN THE SOUTH AND SWPA FROM DEC 7, 1941 TO AUGUST 1945.

***** H. "The medical care rendered by Air Force Medical Officers in unit dispensaries was of high quality throughout the war. Group Aid Stations were not used to any great extent because of the limitations placed upon the type of case that could be treated in these installations. Portable Surgical Hospitals proved to be extremely useful in the care of Air Force troops when they were under the operational control of the Air Forces. However, the Air Forces did not have administrative control of these units. All Air Force troops were hospitalized in Service of Supply hospitals. This procedure was unsatisfactory to the Air Forces because of the administrative problems which resulted, though the professional care rendered was excellent. The Air Forces were unable to obtain information on these patients concerning their location, the probable period of hospitalization, their eventual disposition, and the diagnosis and type of treatment given. As a result efficient forecasts of future replacement requirements were not possible. The assignment of hospitals of all categories to the Air Forces was, therefore, requested but not approved. The designation of certain General Hospitals for the reception of Air Force troops did much to relieve some of the administrative problems confronting the Air Forces in the hospitalization of their personnel. An Air Force Convalescent Training Program was developed and used in conjunction with the General Hospitals designated for reception of Air Force patients. This program proved to be an efficient method of conserving manpower by rapidly reconditioning Air Force patients. Without this program it would have been necessary to evacuate many of these patients to the Zone of Interior."*****


L.K. POEL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS

***** E. "The hospitalization of cases in British military and civilian hospitals, made necessary at first because of the widely dispersed and limited number of American hospitals, was discontinued as a general policy when American hospitals became established within reach of Eighth Air Force airdromes. The coordination and service given our forces by British institutions was on the average satisfactory. It was also decided by the Commanding General, ETOUSA, that the evacuation of casualties by air in the European Theater would be the responsibility of the Air Forces.

Furthermore, and finally, hospitals of the Service and Ground Forces and the United Kingdom were established without regard to troop concentration or the military medical problems of the Air Forces within the theater. For example, at Burtonwood, England, where approximately 20,000 Air Force troops were stationed, only a dispensary was available for medical service. At Prestwick, Scotland, which was the serial port of embarkation for patients enroute to the Zone of Interior, the nearest hospital was 50 miles distant. As a result of such poor distribution and the limited number of US Army hospitals, a large part of the hospitalization of Eighth Air Force patients was accomplished in Royal Air Force (RAF) and British Civilian Emergency Medical Service Hospitals. Many of these hospitals were definitely substandard according to American standards.

During the remainder of the war in the European Theater of Operations, The Surgeon General jealously guarded the right to control theater hospitalization. At the same time, however, The Air Surgeon was quite anxious for the Air Forces to control its own hospitalization in the theater. This situation between the two offices must be taken into consideration in evaluating the various reports of theater hospitalization.

Hospital Facilities for AAF Lag far behind Schedule. Inasmuch as Services of Supply was responsible for all hospitalization in the European Theater of Operations, this section is concerned principally with the efficiency of the hospitalization service furnished to the Air Forces, and, incidently, to the efforts of the Air Forces to secure control of its hospitalization. That hospital facilities and supplies, like other equally important war measures, should be far behind schedule was not unexpected. The reasons for this situation, however, were apparently not fully appreciated by all the officials involved. Col. W.S. Woolford, in an inspection report of 7 May 1943, stated that the development of the hospital program for the American Forces in the United Kingdom was "beset with many difficulties, and is an amazing story compounded of official British inertia, evasions, inability to appreciate or unwillingness to accept the American hospitalization plan, and of labor and material shortages."

Maj. Gen. Ira C. Baker, Commanding General, Eighth Air Force, complained about the unsatisfactory situation of hospitalization for the Eighth Air Force on 18 February 1943. The chief difficulty seemed to be the delay in opening American hospitals. He stated that it was necessary to hospitalize approximately 30 percent of Eighth Air Force personnel in British hospitals. This was unsatisfactory because the British hospitals were often understaffed and, hence, not able to give the detailed care desirable. Another unsatisfactory situation was the location of American hospitals in areas distant from Air Force stations resulting in long lines of evacuation. Three charts were attached to show that American hospitals were chiefly located in the southern part of England where there were practically no Air Force units. There were 5,600 Air Corps troops in the Burtonwood area and

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS, CONTINUED:

the nearest American hospital was 75 miles by road. Neither was there a hospital functioning in the London area where there were 5,600 Eighth Air Force troops. It was noted that a hospital was proposed for the St. Albans area north of London; however, this site would be 22 miles from Wide Wing and 20 miles from High Wycombe. That the hospital situation was unsatisfactory is evident. But the reasons for this unsatisfactory condition, however, were not due to the lack of efforts on the part of the Chief Surgeon, European Theater of Operations.

Upon receipt of the letter from General Eaker, Brig. Gen. Paul H. Hawley Chief Surgeon, European Theater of Operations, answered with a complete statement detailing his efforts to secure hospitalization, and pointing out the difficulties which he had encountered. General Hawley was of the opinion, after having received General Eaker's letter, and after a recent conversation with him, that the Commanding General, Eighth Air Force, did not have all the facts in the situation. This opinion was responsible for the detailed history of the hospital program which was sent to General Eaker.

A part of the difficulty was attributed to the British system of committee planning which was adopted by the theater. It seems that the theater general staff abdicated in favor of the London Bolero Committee as soon as it was formed. The committee which was responsible for hospitalization was the Provision of Medical Services Subcommittee, which was a sub-subcommittee reporting to the Accommodations Subcommittee which, in turn, was responsible to the London Bolero Committee. Therefore, the committee which was responsible for hospital service was far down in the organizational scheme. Then General Hawley found, to his surprise, that "none of these committees, not even the London BOLERO Committee itself, had the slightest authority to order anything to be done, or anybody to do it". Taking cognizance of this situation and the fact that the hospital program was falling far behind, General Hawley began a vigorous campaign to get action. Eventually a visit with General J.C.H. Lee to see Lord Portal, the Minister of Works and Planning, did get results.

General Hawley regretted the "inaccurate picture" of the hospital plan as shown by General Eaker's enclosed maps. Attention was called to the fact that general hospitals served the theater as a whole and that their location was more dependent on rail and road communications and success to ports than on the location of troops. Inasmuch as Great Britain included such a small area, practically any hospital existing in the country could be used. That four of five of the hospitals obtainable were in Southern Command is due to the fact that they were absolutely all that were available, and they were not chosen because ground force troops were located here. As for the station hospitals they had to be built, for no existing plants were obtainable. These station hospitals were built in the area where the Eighth Air Force, with a strength of 17 percent of the theater, was allotted 25 percent. This was based on the promise that the Eighth Air Force would be suffering casualties while the ground forces stationed in Britain would not.

Although the whole hospital program had been delayed, there was less delay in the hospital construction for the Eighth Air Force than for other units. General Hawley put it in this language: "You have 25 percent of your new station hospitals; the rest of ETO has exactly none! I know that this is a little solace when you need all your hospitals, but I hope you do accept it as evidence that we

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS, CONTINUED:

have tried harder to get you your hospitals -- only because you needed them more -- than we have tried in the program as a whole. It would appear from this correspondence that the delays in hospital construction could not be attributed to the lack of efforts on the part of the Chief Surgeon, European Theater of Operations. Colonel Woolford, referring to "considerable controversy between the Surgeon, Eighth Air Force, and the Theater Surgeon" over lack of American hospitals for the Eighth Air Force, came to the same conclusion. After a study of the correspondence relative to the hospital program, he was convinced "that the Theater Surgeon was a victim of circumstances beyond his control, and is blameless".

Notwithstanding a lack of a full appreciation of the true hospital situation, as evidenced by the letter of General Baker, the fact remains that lines of evacuation to general hospitals were long, and that the progress in constructing station hospitals was very slow. The complaint of the Air Forces, then, was a means of initiating action to correct this unfortunate situation.

The Air Surgeon, however, continued his efforts to secure the authority for the Air Forces to control hospitalization in the theaters. To provide a justification for this cause, The Air Surgeon sent out a detailed questionnaire, in March 1944, to the surgeons of all air forces asking specific information on hospitalization furnished by Services of Supply. In a letter to Col. Harry G. Armstrong, Surgeon, Eighth Air Force, The Air Surgeon stated: "The possible saving of man-days which would accrue to the AAF if AAF theater hospitalization were authorized, continues to be a matter of great concern to this office. The answers to this question in the questionnaire sent out March 1944 from this office reveal that an important saving could be effected."

It appears, however, that by August 1944 General Grow no longer agreed with the Air Surgeon in his contention that man-days would be saved if AAF theater hospitalization were authorized, that is, in the ETO. In a letter to the Air Surgeon, which was approved by General Grow, it was stated that "no appreciable saving of man-days would result in AAF theater hospitalization were established. Excellent cooperation in this regard has been secured from SOS hospital units serving the Eighth Air Force."

On the question of policy concerning hospitalization, the board concluded: "In view of the long established system of hospitalization in the ETO and contemplated new operations, it is felt that any change in the general principle of hospitalization in the ETO at this time should not be recommended."

These field hospitals seemed to satisfy the peculiar demands of a tactical air force. When the fighter groups were operating from fixed bases in Britain, where hospitals were plentiful, SOS hospitals could be used; however, on the Continent, the tactical air force was either operating from forward fighter fields or from behind airfields being constructed in the Army area and ahead of Communications Zone installations. Hospitalization for Air Force personnel then would have to be either in the Army hospitals of the forward areas or to the rear in Communications Zone hospitals. The field hospital units proved to be extremely desirable because they were located from the standpoint of the air field. The rapid movement of tactical air force elements made planned hospitalization dependent upon it being a function of the air force.

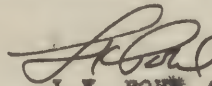
RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - AFTAS. CONTINUED:

Evacuation in the United Kingdom. Wounded or sick Air Force personnel received initial treatment in Air Force dispensaries. Patients whose condition required further treatment were sent by ambulance to SOS station hospitals and general hospitals. If patients were hospitalized 30 days or less they were returned direct to their units; however, if they were hospitalized for a longer period than 30 days they were returned to Air Force Replacement Centers.

Evacuation From the Continent. Battle casualties and sick and non-battle injured were moved from advance airdromes in Army areas to evacuation hospitals after treatment in aviation dispensaries. From Air Force installations in the Communications Zone, patients were sent from aviation dispensaries to the nearest station or general hospital. Personnel from the field hospitals or platoons of field hospitals likewise were sent to the nearest station or general hospital. *****



L. E. POHL, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACTS of statements made by Brig. Gen. Robert C. McDonald, MC SA (Retired)
21 April 1944, before the Subcommittee on Military Medical Resources.

*****H. "Hospitalization and Evacuation Policies within the Combat Zone, and evacuation to the Communications Zone and to the Zone of the Interior. Hospitalization in the Combat Zone should be in mobile medical units and should be of short duration.

We started into Australia and into the Southwest Pacific with the idea we were going to have to put up lots of prefabricated buildings, and it would have been a grand thing if we had had those ready, but I think that part of the war was about over by the time we did get them over. I didn't go over to the theater very much, but I suspect they weren't ready.

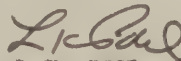
I do think we should have prefabricated buildings ready in time the next time, because they are of very great advantage in the tropics. I think the Navy, from reports I received, were ahead of us in that respect. They did have better provision for their mobile hospitals, small ones, than the combat area.

I think that the Division area, for example, up near the front, really shouldn't try to hold patients more than two or three days. In maneuvers and in combat in the first world war, I found that was impracticable if you are getting very many wounded and sick. You would have to clear those units because they have to be kept mobile and back in the Army area in time of active combat two weeks would certainly be a maximum, or in the case of a badly wounded man who had no prospect of returning to the front lines soon, or a seriously ill man, return him to the rear as soon as he was physically able to stand the transportation.

Regarding the policy of evacuating to the ZI, I think that depends so much upon the situation, that is, the size of the war, the nature of it, the strength of the enemy, the lines of communication, and the distance from the home territory, and so on, its very difficult to determine that.

I think that we first started out in the world war to go on a 90 day policy, and I think some of our patients from India got to San Francisco about the end of the 90 days and were ready to turn right around and go back, and they did get well, and that was too short, of course, a time for a theater like that.

On the other hand, I believe it was General Hawley's policy in England to retain his people six months. That was before the active combat started, however, during the assembly and mobilization of the force for the attack on Europe, and it apparently worked all right. It did enable him to build up hospitalization which would be ready for the peak load when it did come, which I think was a very fortunate thing; but somewhere from 90 days to six months is probably the zone for retaining patients in the communications zone or in the theater of operations.****


L.K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY:

(Extract of statements made by Colonel Thomas J. Hartford, MC, USA on 23 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

***** "h. I am speaking of medical cases, tonsillitis, little fevers. It has been known generally that hundreds of thousands of these individuals, due to lack of facilities in forward areas, found themselves in rear medical installations developing "hospitalitis" to major extents and thereby preventing their return to a full-duty status inordinately.

That's true, but part of that then was lack of interest on the part of the medical personnel to retain those cases. They weren't interested, and with our present emphasis on professional medical care only I think it will be worse next time. I don't think it would make any difference how many installations you put out there. I still think the people will find a way back; but I think this convalescent hospital, especially as it's being reconstituted, is a good idea. We kept a lot of patients in there. I don't mean to say we were the only Army that took care of these people, because we didn't take care of them either. We went across the Rhine. For 26 days every patient we had was hauled out by air. It was mighty easy to take them down there and get rid of them in a hell of a hurry. The Air Corps hauled out about five or six hundred a day for us for about a month straight without a day's gap, and they went; but if we would have had a general hospital or something in the front line, I still think we would have lost a lot of them we shouldn't lose, that should be kept in the forward area. I don't know how you are going to obviate that. I mean, I think there is more to it than lack of facilities.

Relative to air evacuation, in the theater I was in certainly they did wonderful things, things we didn't believe they could do. They were hauling patients out regardless of what the history says on Omaha Beach about D-2 or 3, due to their skill and daring; but it was always, insofar as we were concerned, a bonus, and when the Air Army became tactical quite frequently we couldn't depend on it due to the necessary secrecy in planning, and so forth. We at times had our holding units filled with patients only to find out at a very late date that we didn't have any planes coming in to pick up the patients, and those holding units were not staffed to keep these people very long.

The system and the liaison I don't think could be improved upon very much, but the whole fact was that it was a bonus, and during the latter stages we couldn't depend on it as much as we would like.

RESTRICTED

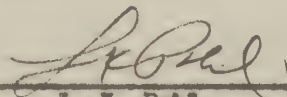
CONT'D

RESTRICTED

**** "H. Now, whether we could have planes for evacuation only, I am not prepared to defend, because it would have to be defended upon an absolute need and the fact that it couldn't be worked out any other way. Perhaps if a certain number of planes could be set aside for administration, supply and evacuation, that that could be worked out, but I think it's something that is important, and I think there has to be some compromise between the people who say, "Well but you have ambulances, there is no reason why you shouldn't have your own airplanes," and to people that say it has to be strictly on the basis of a bonus.

"Hospitalization and evacuation policies." Well, I think you have to have a hospital evacuation policy if you are going to do any planning, even if it has to be changed occasionally and it can't be followed absolutely. In other words, if you have a 120-day evacuation policy and a man was going to be in the theater for twice that long, you want to send him home, of course you have to wait until his condition permits his being transferred to the zone of interior.

I think that perhaps we should be thinking--and someone may be--about utilizing air transportation; that we may be able to cut down our over-all requirements of fixed beds in theaters by transferring more people to the zone of interior as our lift in planes becomes greater, development, which I suppose they will. *****



L. K. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. R.R. HERRING, JR., (MC) USN ON 22 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** H. "Another thing at Saipan in our planning for our hospitalization ashore, at the last minute we were assigned a corps medical battalion which had never had a day's training. They had never even seen their equipment or set it up. And we had one field hospital from the Army, plus two surgical teams to back up three divisions.

At that time I didn't realize how inadequate that support was, until I went to Okinawa and saw the way the Army back up their divisions. I think they had 14 field hospitals on Okinawa backing up a front of three fighting divisions. That is a tremendous difference. We didn't at that time, let me say, realize the amount of hospitalization that was necessary on the target.

My division hospital had a designated capacity of 500 beds. At one time we had 1,543 patients.

I have no further comment, but I would like to reiterate that I think the Army should accept responsibility, and the Navy should actually get out of temporary and semipermanent hospitalization for the reason that we do not have the personnel, and we never will, with the background to make one of those things function well enough.*****

L. K. FOHL
L. K. FOHL, Colonel, MC

TRUE EXTRACT COPY (Ltr Brig. Gen. G.R. Kannebeck, Dental Corps, dtd 7 May 48)

***** H. "Akl maxillo facial injuries which will require long hospitalization should be evacuated as soon as transportable to the Zone of the Interior. No treatment other than that of an emergency nature should be given for these cases in the combat or communication zones."*****

L. K. FOHL
L. K. FOHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE MEDITERRANEAN THEAT R
HISTORICAL SECTION - AFTAS

***** H. "Originally no hospitals were attached to the Air Forces in the Mediterranean Theater. Hospitalization was the responsibility solely of the Ground Forces. For several months after the invasion of North Africa the British were responsible for hospitalization in the area of and east of Algiers, and the United States was responsible for hospitalization west of that city in the areas of Oran and Casablanca.

During the first month of the invasion several United States Air Forces units were established in Tunisia. The nearest American hospitals were in Oran, some 800 miles distant, and British hospitals in the Tunisian area were few in number and overcrowded and were frequently moved to keep contact with ground forces. Moreover, unfamiliar routines and the rather formal atmosphere of British hospitals lowered the morale of American patients, and there was considerable danger of their becoming lost to their units in the British evacuation chain. In these circumstances great reliance was placed upon evacuation by air from improvised group dispensaries and holding stations.

In March 1943 American hospitals became available in the area of Constantine and in Tunisia, relieving to a great extent the critical situation. Some difficulties, however, persisted. The rapidity with which Air Force units frequently moved from airdrome to airdrome and the invariably wide dispersal of airdromes over long lines of communications made adequate hospital coverage extremely difficult. In many areas hospitals were separated from large airdromes by from 30 to 80 miles of almost impassable roads. Moreover, during the final phase of the Tunisian Campaign brief crises occurred when movements of the Ground Forces left the Air Force units in a relatively isolated position with respect to hospitals.

The occupation of Pantelleria in June 1943 presented a problem unencountered previously, since no Ground Forces were employed in that mission. In order to provide hospitalization on the island the 34th Station Hospital was attached to the Twelfth Air Force for the three months' period of occupation by Air Force units and was placed under the supervision of the surgeon of a provisional Air Force organization designed to administer the whole island.

During the campaign in Sicily in July and August 1943 a large portion of the casualties were evacuated to American hospitals in North Africa. American hospitals in Sicily were first located in the vicinity of Palermo, while several British hospitals were established in Catania. Owing to the difficulties experienced with British hospitals, American units stationed in the vicinity of Palermo were employing air evacuation as late as May 1944.

The end of the Sicilian Campaign found several Fighter Groups and a Fighter Wing in the Milazzo area, other Fighter Groups and a Fighter Wing in Palermo and Troop Carrier units in Catania. A platoon of an American field hospital was stationed in Milazzo during a part of August. After its departure the units in that area had to evacuate patients westward along the northern coast to an American evacuation hospital near San Stefano. The situation in Milazzo became increasingly difficult as troops poured into that area in preparation for the invasion of Italy.

RESTRICTED


RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE MEDITERRANEAN THEATER
HISTORICAL SECTION - AFTAS, CONTINUED

During the remainder of the year, as tactical Air Force units became relatively more stable, many of the difficulties that existed previously disappeared. The elements of the Twelfth Air Force that participated in the invasion of southern France, to be sure, experienced temporary hardships with respect to hospitalization. Evacuation hospitals accompanying the rapidly advancing troops unavoidably left Air Force units with no hospitals nearer than 40 or 50 miles. However, the arrival of fixed hospital installations in the rear, corrected this unsatisfactory situation. Elsewhere -- in Sardinia, Corsica, and western and southeastern Italy -- ample hospitalization facilities were at all times available to units of the Twelfth Air Force. For the Fifteenth Air Force in eastern Italy hospitalization facilities were excellent -- a circumstance attributed in part to the fact that hospitals in that area were attached to the Air Forces.

Many of the difficulties in hospitalization experienced by Medical Department officers responsible for medical services in the Air Forces were attributed to the fact that no hospitals were assigned to the Air Forces in the theater. Although assignment was considered preferable, to attachment, it was generally agreed that the attachment of several hospitals to the Air Forces in eastern Italy greatly improved the situation in that area with respect to hospitalization of Air Force personnel.

Although the attachment of hospitals to the Air Forces proved to be, on the whole, a satisfactory arrangement, there remained problems that arose from the lack of training and experience on the part of hospital medical officers in aero-medicine. However, as hospital personnel became conditioned to the hospital requirements peculiar to aircrews -- a situation that developed in attached hospitals and in many instances in other American hospitals in areas occupied almost exclusively by Air Force troops -- excellent services were rendered.*****


L. K. FOHL, Colonel, MC

RESTRICTED

RESTRICTED

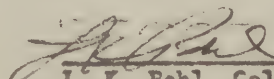
EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** (H) 1. The main factors demanding changes were changes in the tactical situation. I do consider it necessary that a goal to establish evacuation policies be made knowing for certain that changes will have to be made. I think they were too rapidly followed, that good judgment was not always used in selection of cases for evacuation and professional decisions were not always good for reasons that were not professional. In many instances professional officers did not make the decisions. An evacuation officer made the decisions and he did it by rule of thumb to the great detriment of the Army from the standpoint of manpower. I believe Chiefs of Service in the hospital should decide who would be evacuated and these decisions should be carefully checked by the commanding officer to see that these policies are carried out.

"2. Yes. There were too many medical cases evacuated in the forward areas. Increase bed capacity for medical cases. Doctors don't have to be specialized but units could be specialized. I believe the basic organization of the evacuation hospital as now established is sound because the evacuation hospital as now organized has sufficient personnel to carry on in combat for a sustained period. In times of stress, however, they do need the addition of surgical teams to augment them.

"3. I believe there are some bad points to it. Very often the rear echelon does not feel the pressure up forward or the rear echelon doesn't have sufficient transportation to evacuate the casualties. I really believe the Army should be allowed to evacuate its own casualties to the rear if it has to but should be provided with sufficient transportation to do so. I believe the CZ should have the responsibility. I believe the theater commander should be cognizant of his responsibilities in this matter. Re recovered cases - yes. There was considerable loss of manpower by overstaying in hospitals and by patients being evacuated further to the rear than necessary because the Medical Department had no place to put them. A definite directive from the highest echelon of command in regard to these responsibilities is my recommendation. The key obstacle of removal of casualties to ZI was lack of transportation both in number and time of arrival. There was no even flow of transportation towards the theater to remove casualties. A more efficient system could be developed by having staff control of hospital ships or staff representation with the Transportation Corps to notify the theater surgeon in advance of the arrival of personnel ships giving the casualty carrying capacities of each ship and by having representation in the highest echelon of the Air Force to be assured that maximum use could be made of planes returning from the theaters of operation. The Surgeon Generals should be cognizant of their responsibilities in evacuation theaters of casualties and should have the proper staff machinery set up to discharge them.

RESTRICTED


L. K. Pohl, Colonel, MC

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

(Continued)

"I think the hospital ships should be under the staff control of the Surgeon General. The same with the air evacuation system. This plan applies particularly now in view of the large casualty carrying capacity of the new planes.


"6. The only solution I see to this problem is to have sufficient hospital beds in the proper areas to obviate the necessity for passing them from one hospital to another. I believe the solution to this practice could be solved by grouping sufficient hospitals of certain types in the forward areas to preclude the necessity of transferring them on back, referring particularly to convalescent installations. I believe observation is more applicable to the communication zone, but should be attempted only if there is an adequate grouping of hospitals.

"7. I think the main factors interfering in the control of evacuation was lack of facilities, such as trains, planes. Staff interference came in in the matter of priorities of movement. The lack of communication plays a very important part, in the operation of the air evacuation scheme, particularly. No great difficulty was experienced in the movement of trains or ambulances.

"8. No. G-1 replacement pools would have a tendency to waste manpower in view of the necessity for transfer of all patients leaving hospitals through the replacement depot system.

"9. I believe convalescent hospitals are absolutely essential in both the combat zone and communication zone. I believe the hospitals in the communication zone should have convalescent sections. It is more economical to attach to hospitals themselves. Re 1,000 bed - yes. I believe it will."*****

***** "I do not believe that the Engineering Corps fulfilled its responsibilities in regard to the construction and maintenance of medical facilities during the war. In the first place, they were not cognizant of their responsibilities. In the second place, they did not have the necessary equipment to take care of the hospitals. I would say that I do believe that there should be a separate section of the Engineering Corps in peace and war for hospital construction."*****

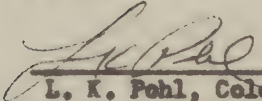

L, K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Arthur B. Welsh, MC, USA
dated 19 April 1948)

***** "h. These were command decisions. Consideration in World War II should have been given to a sixty day overseas evacuation policy to the zone of interior, utilizing air evacuation to the maximum and employing fewer fixed hospitals within the communication zones. There were many contingencies that had to be considered in establishing an evacuation policy for the combat zone. In general an army couldn't plan to implement an evacuation policy of more than fifteen days duration. This was not always possible. The evacuation policy was principally an aid in planning. The means one had determined what one could do and formed the policy. In brief the evacuation policy was only a pre-determined course of action to be taken during an operation in regard to casualty evacuation and hospitalization." *****

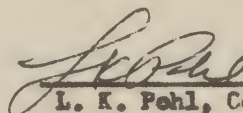

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Richard T. Arnest, MC, USA, (Ret.)
dated 19 April 1948)

***** "In the army area a two week policy or longer should be established for return to duty casualties. For this purpose large evacuation hospitals and convalescent hospitals should be utilized. Casualties requiring a period greater than one month for recovery should be sent to fixed hospitals in the Communication Zone. A 90 to 180 day policy for evacuation from the Communication Zone to the Zone of the Interior should be established depending on the facilities for evacuation and holding facilities in the Communication Zone. It must always be borne in mind that the longer the holding policy the greater will be the bed requirement in the theater. Air evacuation should be utilized to the maximum and definitely planned for. Ambulance convoy and hospital trains will be used when practical. In the Communication Zone existing buildings should always be utilized for hospital purposes when available; semi-permanent construction, second, and tent hospitals as a last result." *****



L. K. Pehl, Colonel, MC

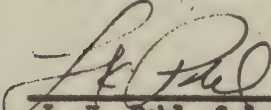
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Robert E. Peyton, MC, USA
dated 19 April 1948)

****In the European Theater where I served, the Army provided fixed hospitalization for the Air Force. As I see it, under the conditions which existed separate hospitalization for the Army and for the Air Force could have been to the advantage of neither. The Navy did occupy for a while a large hospital plant at Southampton. The plant was procured originally by the Army and it was understood that the facilities were for joint use. This could be regarded as helpful assistance rather than as duplication. There is no doubt that the presence of Army, Navy, and Air Force personnel in a hospital of another armed service increases administrative difficulties. If we are to cross-hospitalize in any large number it will require representatives from the respective forces for administrative and disciplinary control of their own personnel.****

RECORDED


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C.B. Camerer (MC), U.S.N.,
Retired dated 21 April 1948)

****(h) Probably the greatest advance in the transporting of casualties to the rear from combat areas was their evacuation by means of air craft. This was found by trial to be feasible and expedient, saving many lives and vastly raising morale. This service should be amplified and definitely provided for in all active combat areas. The general measures adopted and found of proved efficiency as employed in World War II should be scrutinized and improved along the general lines of existing policy. It is mandatory that as many casualties be cleared out of front areas as rapidly as possible and the combination of first line care, evacuation to "back areas" and thence to zones of the interior in order to afford better medical care and at the same time relieve active combatants of their presence, with attendant logistic problems, etc., appears." ****

RECEIVED

L.K. Pohl

L.K. POHL, Colonel, MC

RESTRICTED

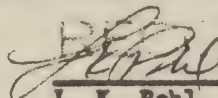
531

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. R. Urban (MC) USN
dated 28 April 1948)

***** "(h) Hospitalization and evacuation policies within the
combat zone, and evacuation to the communication zone and to the
zone of the interior.

"(1) In the Army in certain instances many base and general
hospitals were placed in poor locations with reference to lines of
communication." *****

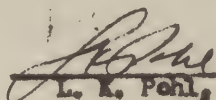


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTEDTRUE COPY EXTRACT(Letter, Captain Emmett D. Hightower (MC), U. S. Navy
dated 21 April 1948)

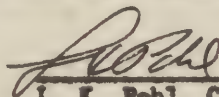
***** "(h) It would seem logical to continue the policy adopted in the last war of evacuating from the combat zone, all casualties which obviously would not be restored to full duty within 30 to 60 days. Further screening in the communication zone would determine the policy of evacuation to the zone of the interior." *****


L. K. Pahl, Colonel, MC**RESTRICTED**

RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT HISTORICAL RECORDS OF WORLD WAR II. (Ltr. to: Whomever it May Concern dtd 6 Feb. 1943 unsigned (submitted by Col. Robinson, but probably prepared by Maj. Rergerman)

***** "Revision of the T/BA and Controlled Items making provisions for portable X Ray equipment, microscope, and laboratory equipment in order that more definitive care can be given to combat crews, making the units, more or less, independent rather than dependent on a mythical chain of evacuation."*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

***** "(H) 1. An evacuation policy properly belongs in a medical plan for any operation. In the type of operation we experienced in the Pacific, an immediate evacuation policy was of necessity the only one which could be adopted. The planning virtually contained a provision that the policy would be increased when it could. That was the only type of policy that we could set up and therefore I can't answer the question.

"We maintained the immediate evacuation policy as planned and we extended the policy as soon as we possibly could. The main factors that demanded change, of course, were enemy actions which necessitated the supporting ships to leave the area momentarily, typhoons, and other unforeseen things which seemed to always come up during an operation.

"(H) 2. I think it's true of any case that entirely too many purely medical cases and entirely too many minor surgical cases are evacuated out of forward areas. There is only one way you can possibly stop this and that's to have additional facilities so that you can hold these people in the forward areas. Until those facilities are available, the surgeon and the personnel officer for the commander must mutually decide or present to the commander for decision whether he wants to sacrifice potential replacements in the form of sick and slightly wounded, or how he wants to handle the replacement problem. More hospitals up front would very definitely correct this error. If you have enough hospitals you don't have to send anybody out.

"Standards of medical service in any combat area depend upon the facilities at hand. If the commander insists on higher standards he will get better medical service. If he insists he doesn't need as much medical service as the surgeon recommends, the commander must understand that the responsibility is his.

"As for specializing hospitals, I personally prefer not to specialize them in the combat areas. An evacuation hospital is a specialized hospital surgically speaking, because it is designed for combat. From my knowledge of the evacuation hospital, having never seen one operate, I would say evacuation hospitals could be modified for medical cases by merely relieving surgeons—operating surgeons, I mean, temporarily and replacing them with medical-type personnel.

"I feel very strongly that we should keep our personnel flexible to modify our hospital needs dependant upon the local situation. We can very well have different needs behind a unit as small even as a corps, in which case one hospital today may be full of surgical cases and need all the surgical help it can get, and another hospital may be running relatively light, or might even be conceivably having a medical-type epidemic."

RECORDER**RESTRICTED** L. K. Pohl, Colonel, MC

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

"It would certainly be a shame if they were specialized to a point where we couldn't move the personnel.

"As far as key personnel is concerned, I think I have kind of touched on that. I think in line with our current thinking, which is based upon experience of a great many people, a hospital itself can consist of materiel and administration to keep it going, and then it can be staffed as the situation indicates within, of course, reasonable limits. And I feel just as in calling doctors to service during the mobilization, we shouldn't call the doctors until they are needed. I don't think we need to keep key personnel in a hospital that is inactive or relatively inactive. I think we should find some way to keep our personnel where they can be doing the type of work they are best qualified to do.

"The few cellular teams I saw, I have no objection to whatsoever. I think they are fine things and I wish there were a lot more.

"(H) 3. Our teaching of placing responsibility for evacuation on the next rearward echelon in my opinion is entirely sound. I don't see how the forward echelon can be expected to do any more than indicate any additional need for help in this connection. I feel, just as in supply, the responsibility should be for the rearward and presumably less immediately occupied echelon to keep the forward echelons cleared out from a morale standpoint and to keep them as mobile as possible.

"The engineers are so much interested in this responsibility from the rear that they are making a study right now as to whether they can adopt something like that in the engineers and how to handle their repair jobs.

"I would like to answer the question by stating from a practical standpoint, since we usually have to return the patients, let's be given the responsibility for doing it and then the necessary means with which to discharge that responsibility.

"I will make the same remark that I did about air evacuation. I don't think the medical department should actually operate, but I do think the medical department should control the hospital ships, hospital planes; any evacuation vehicle should be under the control of the surgeon general's regulating system, and certainly is more than ever feasible with large planes."

RECORDED

[Signature]

RESTRICTED

L. K. Pohl, Colonel, MC

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

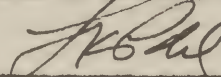
***** (H) 8. In any unit in which I had any control, policies were sufficiently general so that the local unit commander could take advantage of his own initiative and knowledge within reasonable limits. We tried never to hamstring either an administrative or professional individual. I believe that if you did hamstring people to that extent that you certainly would create a waste of manpower as far as salvage of groups of certain cases were concerned.

"(H) 10. I do not favor a separate evacuation and treatment chain of facilities for NP cases for very practical reasons. I can see some of the arguments that are presented from the morale standpoint, but it's just in my opinion entirely too involved to segregate these people all the way along the line into a little private evacuation system of your own.

"I do recognize the value of concentrating them as far forward as possible, and the scheme of trying to hold them within the division areas certainly salvages a great many of these people, but that isn't a separate evacuation system.

"(H) 11. If you are lucky enough to be able to keep minor cases in forward medical units until their recovery, you certainly should keep them busy.

"(H) 12. My answer to 12 is: yes, sir; it's more theoretical and personal knowledge, but I certainly do think you have to have continuous contact, and the rear echelon being responsible for the evacuation certainly should have a representative in the forward echelon so your contact can be immediate and continuous."*****

RECORDER


 L. K. Pohl, Colonel, MC
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL CORNHILL, MG USA, 30 APRIL 1948.

***** H. "Hospitalization and evacuation policies within the combat zone, and evacuation to the communications zone and to the XI. - The need is recognized for a basic policy which will retain sick and wounded as far forward as possible combined with rapid evacuation of patients of over 90-120 day class to the XI. I am sure you have discussed that before.

Convalescent hospitals were excellent as used late in the last war with active rehabilitation. Maintain the patients unit identity for morale. Rapid return from CZ hospitals to Army convalescent hospitals. If there is any doubt, let the decision be made in the Army zone; that is, at the convalescent hospital.

Avoid running these men through replacement pools where they lose unit identity, and it also saves time.*****


L.K. POHL, COLONEL, MG

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON DE WILLCUTTS (MC) USN
4 May 1948.

***** H. "What is your idea of the methods of hospitalization and evacuation policies within the combat zone and evacuation to the communication zone and to the zone of interior?"

REAR ADMIRAL WILLCUTTS: Evacuation in Okinawa was carried out largely by service hospital ships and by the air service. It was excellent. The patients were evacuated promptly back to base hospitals where they were screened; and then, depending upon the planning of the next engagement, the next project, dates were set up accordingly so that sick boys of 120 days would be evacuated back, or 90 days, or 60 days.

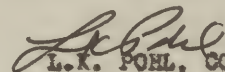
On Okinawa I saw any number of boys go aboard our hospital ships and by the time they got back to Guam they left the ship on their own and in pretty good condition. They were exhausted, mental casualties at Okinawa, and four days later they were recovered.

It seemed odd that because of the so-called Geneva Convention they had to be put in a hospital and processed, which took a long time and perhaps many man hours and much manpower was lost. These boys, many of them, wanted to go back, but because of the Geneva Convention rules they were taken ashore and the hospital ship came up empty.

Again, the next war will be total war; and I feel that we can save, and should save, everything that we can to step up efficiency. I think that should be considered. I see no reason why a hospital ship shouldn't transport convalescent patients that will be discharged at the war beach as well as a thousand miles back.

I might stress one point. In the Services we have, of course, what you might term total medicine -- preventive, curative, and so on. And there is a great loss of man hours when we make an error in screening who should come back. Weeks and months are lost. That certainly should be given very careful study -- what you are going to do with these boys that can be utilized other than in combat.

REAR ADMIRAL ANDERSON: There is one difficulty in handling large numbers of casualties that probably contributes to the thing, and that is the lack of facilities to take care of such large numbers speedily. You have got to make room for additional casualties. That happened in the Pacific at Okinawa, and the same thing was true of Guam. The hospitals were full, and we had to do something about it. And undoubtedly we sent back many that should have been retained.*****


L.K. POHL, COLONEL, MC

539

RESTRICTED

H

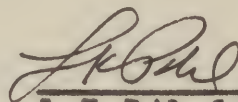
RESTRICTED

TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA,
13 May 1948)

MAJOR GENERAL KENNER: *****The next question has to do with hospitalization and evacuation policies within the combat zone, and evacuation to the communication zone and to the zone of the interior. That is dependant upon the situation at the theatre of operations and some other factors.

One remark I would like to make is that I believe that the communication zone should support the armies closer than they did in the last war. The communication zone should be accorded, in some situations, the privilege of going into an army area. Most army commanders don't want the SOS in any part of their army area. It is a combat area that they want to reserve for themselves, for obvious purposes. However, in certain situations, particularly in a fast moving situation, I believe the medical lead on armies could be materially reduced by permitting the communication zone elements to establish themselves within an army area.

We ran into, several times, notably in General Patton's Third Army, when they had a front of some 400 miles and a depth that was almost as much. And where evacuation hospitals had been established they did what in effect the general hospitals did. They were doing all the work of general hospitals and were tied up. In those instances I believe it would have been to the advantage of the army to have permitted a communication zone outfit to have been established in the army area.*****



L. K. Pehl, Colonel, MC

RESTRICTED

RESTRICTED

- D-1 i. Hospitalization and evacuation policies within the zone of the interior with special reference to construction, distribution, and staffing of military hospitals.

I. DISCUSSION

1. The recommendations as to size, favor an average of 750 to 1000 bed normal operating capacity for General Hospital type installations. It was felt their size should not exceed 1500 bed capacity, although some did favor extreme capacities of 2000 to 2500 beds.

2. Lack of modern architectural design, delay in and lack of suitable type construction with unnecessary rigidity in details of such construction in spite of an on-the-spot medical recommendation for minor changes to improve adaptation for use, are mentioned.

3. Criticism of locations with opinions for and against location in more congested population centers, report of insufficient numbers of special treatment centers in all parts of the country, belief that patients should and should not by particular effort be hospitalized near their home, and opinion for and against special treatment centers are expressed.

4. Mention is made of poor distribution of patients so as to overcrowd some installations with nearby hospitals not utilized to even reasonably full capacity; also to lack of thought for feasible joint staffing and free joint use of facilities by all agencies of the Armed Forces. In the latter regard, the need for uniformity of records, hospitalization and evacuation policies, uniform construction and coordinated staffing is stressed. Overstaffing of General Hospitals was reported frequently.

5. The lack of professional opportunity for Medical Officers assigned to small dispensary and station type hospitals is considered by some as very detrimental to accomplishing obviously desirable rotation of field and hospital assignments.

6. Inadequacy of debarkation medical centers with need for improved evacuation therefrom to proper General Hospitals to receive full final treatment is spoken of.

7. Convalescent hospitals operated in conjunction with large General type hospitals are favored by some and others emphasize the need for such to be located in favorable climatic areas, to be accessible to city recreational features.

8. Adjacency to adequate air landing strips with adequate rail facilities and non-desirability in many respects of utilizing modified hotels etc are other features considered.

9. Opinions vary as to hospital control but consensus seems to be for technical operation through the medical echelon with military command vested in the Army area or Force command representation.

RESTRICTED

RESTRICTED

10. A reasonable utilization of the physically handicapped provided they are mentally capable and of technical value is favored for ZI installations. Full utilization of female components with increased WAC assignments to hospitals is favored.

11. It was felt that excessive niceties and prolonged hospitalization as practiced, even though able to do partial duty, contributed toward non-desire to return to duty status by patients and was a source of loss of potential national manpower.

12. Care of dependents is considered most desirable from morale and educational viewpoints if facilities and personnel are adequate.

13. Planning for location of ZI hospitals in event of another National Emergency was considered a must and nonpolitical considerations with thought toward maximum additional use for civilian populations in event of catastrophes are believed most urgent.

14. Complete Medical control of General Hospitals as separate posts is almost universally advocated. Line command is considered a proper station hospital level policy.

15. Reporting and control of patient census procedures were believed deficient in many respects with prolonged unnecessary hospitalization and unnecessary bed occupancy resulting from personnel management breakdown. It was accepted almost universally that disposition of patients to units should be a hospital function and the wherewithal to do so be provided.

II. CONCLUSIONS

1. Military hospital planning for a possible World War III should benefit immeasurably from the experiences of World War II.

2. Modern architectural design with uniform construction, practical size of installations, proper planning for location particularly in regard to accessibility to an adequate Air Field, and consideration of joint utilization of expanded adequate existing structures with and for possible additional civilian use, are considered essential.

3. In the event of War in the United States strategic concepts should be provided to allow adequate Medical planning for required hospitalization. When and if such occurs, joint military and civilian hospitalization policies will need to be established and ready for maximum coordination and direction of effort. It is believed that in such event National control of most hospitalization by the National Military Establishment will ensue and planning for such contingency should be done now.

4. In the event of war in Foreign Theaters of Operation, the Zone of Interior hospitalization should be exploited to the maximum utilizing air evacuation, adequate and properly located debarkation centers and fullest adaptation of returning cargo planes or special medical planes to large pay loads of patients. Staffing of General Hospitals, plus their operation and control in event of a World War III should be initiated on the basis that the distinction between the military and civilian United States citizen

RESTRICTED

RESTRICTED

will probably no longer obtain to the former degree, in modern total war if it comes to our shores.

5. The designation of numbered Armed Force Hospitals for all such present and future institutions with normal capacity of 1000 or over is believed indicated. All such installations should be capable of providing the complete and varied special treatment presently carried out by Army General and Naval hospitals. In addition, these hospitals might well be earmarked and channelized individually for maximum emphasis to continue the special treatment center idea initiated during World War II if deemed necessary. Thus an installation's designation might well be: Armed Forces Hospital No. 1, 2, 3, 4, etc. with operational control continuing in the vast majority of instances with the parent Force; e.g. Armed Force Hospital No. 1, Bethesda, Md., Navy, "Special Center for Treatment of Malignant Diseases". Another example might well be: Armed Forces Hospital No. 2, Hot Springs, Arkansas, Army, "Special Center for Physical Medicine".

6. To supplement numbered Armed Force hospitals, that medical care to be rendered within a somewhat flexible but general 90 day evacuation policy, should be provided each Major Force. To achieve this the designation might well be Armed Force Regional or Station Hospitals and continuing with number designations to be utilized, regional for those installations ranging from 200 bed normal capacity to 1000 beds and station for hospitals below 200 normal in capacity. In this manner regional or area coverage would be provided with the Force of major troop concentration providing Medical operational control.

7. By the above designations, the psychological concepts and advantages toward unified and coordinated effort but without actual merger are very apparent. The same number would not be utilized for designating an Armed Force Hospital and also an Armed Force Regional Hospital or an Armed Force Station Hospital. Assignment of blocks of numbers would allow for and provide ready identification as to location, size, etc. The terms Regional and Station might well be dropped in usage for designation because of the implication that good medical care is obtainable only in General and Naval Hospitals.

8. Continuing the Armed Force number designation of War-Time Hospitals, fixed and mobile, within assigned number blocks would go far toward simplification of designation and allow for appropriate identification.

III. RECOMMENDATIONS

1. That a study be made to investigate the feasibility of changing designation of Armed Force Hospital as practiced in World War II. That a numerical designation with standardized Policy for type and location, is indicated.

2. Initiating medical military hospitalization planning on National Military Defense level, required to coordinate military and civilian defense in the event of total war involving the United States.

RESTRICTED

RESTRICTED

3. Provide for military medical Armed Forces (Army-Navy-Air) hospital planning in conjunction with Joint Chiefs of Staff War Plans and Strategic Concepts.

4. Joint Armed Forces planning be instituted for standardization of common fixed and mobile hospital unit requirements.

5. That full investigation be made of the practicability of Joint Staffing of Selected Hospitals.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus, (MC) USN
dated 27 April 1948)

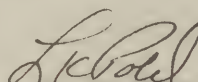
***** "(1) Hospitalization within the zone of the interior presents many problems, some of which are not necessarily to the advantage of the individual or to the services. For example, it is not always best for all concerned to have a patient taken to the hospital nearest his home at the first opportunity. Patients requiring special forms of treatment should be sent to hospitals equipped and manned to care for their particular type of disability. Receiving hospitals should be located at ports of entry into the zone of the interior for the ready reception and screening of patients upon arrival in the United States. Transfer should then be made to the indicated hospital (Amputation Center, Tuberculous Hospital, General Hospital, etc.).

"For the best administration and medical care it is believed that in general, hospitals should be limited in size to 2000-2500 beds capacity.

"In general, hospitals should not be located in congested areas. They should be on main lines of rail transportation and should be in reasonable proximity to cities and towns large enough to provide proper recreation for both patients and staff.

"For the most part war time hospitals should be of temporary construction designed to render the best of medical care for the duration of the war but not to be continued in operation after the war is over and demobilization is completed. Their cost is a part of the cost of war. The acquisition of hotels and other civilian installations are often costly and conversion changes are seldom as satisfactory as are temporary hospitals built for the purpose. So-called convalescent hospitals are a disappointment unless properly located in reference to accessibility and liberty outlets for ambulatory patients.

"Military hospitals should be staffed by military personnel with heads of departments carefully selected to meet the requirements of specialty services and special centers as mentioned in (c) above. The equivalent of 'Waves' and 'Wacs' can be utilized to advantage in military hospitals." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert K. Simpson, USA (Ret.)
dated 1 May 1948)

***** (1) Hospitalization and evacuation policies within the zone of the interior with special reference to construction, distribution and staffing of military hospitals. This has been mentioned under sub par(f). More attention should have been paid to temporary hospital design and construction during World War II. As to distribution of hospitals, (general hospitals) there is no comment other than to the effect that a specialized general hospital could and should serve all branches of the Armed Forces. For example, an orthopedic center for Army, Navy and Air Force, Psychiatric Center, Tuberculous Center, etc. There appears to have been some unnecessary duplication in this respect. Such specialized hospitals should be staffed by the better trained and more talented personnel of course. Every effort should be made to fit "square pegs in square holes". There certainly were far too many instances of mal-assignment in the theatres and in the zone of the interior of World War II, and such mal-assignments contributed a great deal toward lowered morale and discontent. There should be some system of rotating junior medical officers from duty with troops to hospital assignments and vice versa. Month after month of no medical activity other than attending sick call and inspecting latrines and messes promotes stagnation and is an almost universal complaint made by junior officers I have come in contact with.*****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Arthur B. Welsh, MC, USA
dated 19 April 1948)

***** "1. Dispensary beds for short term cases staffed by unit medical personnel could have profitably been used in the zone of interior to a greater extent in World War II, if such dispensary beds had been supported by small, carefully staffed station hospitals. This would have materially reduced the total number of station hospital beds in the zone of interior and would have saved personnel.

"Hospitalization wasn't on an area basis in the zone of interior. It should have been much like it was done overseas.

"Personnel of the armed services were not admitted to hospitals regardless of command jurisdiction. It should have been so directed for the zone of interior as it was overseas.

"Insufficient thought was given to permanency location and post-war use when building hospitals--a long range plan, even though we had the Federal Board of Hospitalization, was not apparent. Too few beds were provided to serve population area densities.

"Insufficient thought was given to expansion capabilities when constructing hospitals, particularly in critical areas.

"Underground hospital structures were never planned. Fortunately we didn't need them for World War II since we won the atomic race. Had we built a few we would have them now for World War III--but probably positioned in the wrong place!

"Agreement among services wasn't reached on hospital design. It appears that the Army Engineers were permitted to run rampant. Hospitals should have been built fifty years ahead in design rather than back twenty, as was done in World War II. Too few hospital architects were employed. The Navy with their Seabees did a better hospital construction job overseas. They had better plans and more talent. The Army could have learned a lesson from the Navy component system in overseas hospital construction.

"Thought wasn't given to joint staffing and joint use of facilities. The fact that each service had to have medical autonomy within its own structure apparently prohibited this desirable feature. Naturally each service has to control its own medical means. Even so we could have had more joint medical operations and joint service. The planners failed.

"Professional consultants could not cut across command channels and serve the Army, Navy and Air. One group could have done the job." *****

L.K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Rear Admiral A. H. Dearing (MC), USN
dated 26 April 1948)

***** (1) Hospitalization and evacuation policies within the zone of the interior with special reference to construction, distribution, and staffing of military hospitals.

In the early years of the war there appeared to be no firm policy regarding the transfer of patients between hospitals within the United States. Later a policy was enunciated of transferring patients, who were able, to a hospital near their home. This was desirable from the standpoint of morale of the patient and his dependents but, in many cases, there were no specialized hospitals for the treatment of certain injuries or diseases that were near the patient's home. As a result patients who were sent to these special hospitals were extremely unhappy because others who were injured with them left the debarkation hospitals to go to their home while they, themselves, were transferred to some remote point. It is suggested that in case of future war such special hospitals be designated throughout the country to eliminate this difficulty. At the Port of Embarkation in San Francisco, the large hospital at Oakland was forced to act both as a receiving hospital and a general hospital until early in 1945. I believe that the same situation held at Seattle and San Diego. If possible, future planning should envision the utilization of buildings or the erection of temporary buildings other than the established hospitals at the Port of Debarkation for the receiving, classification and further transfer of all sick and wounded received from overseas.

Although, there is always pressure from the recognized specialists to have a special hospital established for certain injuries and diseases such as; orthopedics, neuro-surgery, plastic surgery, neuro-psychiatric, psychiatry, etc. I believe that the policy held to by the Navy of designating each hospital as a general hospital for the care of all diseases but, with certain hospitals having emphasis placed on certain conditions, was wise. This policy should be adhered to in the future.*****

L. E. Pohl

L. E. Pohl, Colonel, MC

RESTRICTED

RESTRICTEDTRUE COPY EXTRACT (Letter, Dr. A. R. Shands, Jr. dated 20 April 1948)

***** "The hospitalization and evacuation policies in the ZI at times showed rather poor planning for the distribution of patients, as many of the hospitals were overcrowded while others had few patients with too much personnel." *****

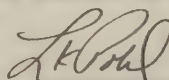


 L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Brig. Gen. Robert C. McDonald, MC, USA, (Ret.) dated 15 April 1948)

***** "(1) Hospitalization and Evacuation Policies within the ZI with special reference to construction, distribution, and staffing of military hospitals.

"(1) Comment and Suggestions: Construction of station and area (regional) hospitals will be required to serve ZI posts, camps, and stations. Construction of general hospitals should be kept to minimum through use of existing Federal hospitals, and existing buildings, such as resort and other hotels, and public buildings. The distribution of station and regional hospitals is governed by the location of troops which they serve. General hospitals should be located in accessible areas, generally near population centers, so the wounded may be hospitalized near their homes. Convalescent hospitals should be established in resort areas where climatic conditions favor recovery. The staffing of hospitals, particularly with specialists, will always present a difficult problem. Each hospital should be staffed so as to be able to carry out its mission. Regional hospitals and large station hospitals should be staffed for definitive general medical and surgical treatment. In addition, general hospitals should be staffed to care for specialized cases. The designation of certain general hospitals as special centers will conserve specialists. The location of general hospitals near large population centers will enable them to have specialists and consultants from civil life assist in special work." *****



 L. K. Pohl, Colonel, MC
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel F. A. Blesse, MC, USA, dated 19 April 1948)

****9. Hospitalization and Evacuation policies within the Zone of the Interior with special reference to construction, distribution and staffing of military hospitals.

"a. Duplication of hospital facilities is frequently heard mentioned as an example of the need for unification. Joint hospitalization should be possible and was actually accomplished in overseas areas where separate hospitals could not be provided. The difference in medical records caused some difficulty and required the assignment of Navy personnel to Army hospitals. It is believed that medical records should be standardized so as to provide one type of forms and requirements common to all.

"b. The staffing of such hospitals should be in accordance with a directive indicating primary interest. Certain hospitals would be predominantly Navy, Army or Air Corps and tables of allowances of personnel would have to be based on this factor. The service with major interest should logically command and furnish the large portion of the personnel.

"c. Hospitalization and evacuation policies within the zone of the interior, particularly construction standards or scale of accommodations and staffing of military hospitals, should be uniform between the services. The lack of a uniform set of construction standards in the past war resulted in considerable variations in the types of medical facilities built by the services and unnecessary expenditures of public funds. With respect to staffing of military hospitals with commissioned, enlisted personnel and civilian MD employees in the zone of the interior, I can see no reason why there should be any difference between the services. As for distribution of the zone of the interior medical facilities, there is no valid reason why, when troops of both services are in a particular area, there should be any necessity for separate medical facilities. To insure efficiency, however, close cooperation and coordination is essential.****"

RESTRICTED

J. K. Pohl

J. K. Pohl, Colonel, MC


RESTRICTED

TRUE COPY EXTRACT (Letter, Dr. Howard A. Rusk to Secretary for Air dated 27 January 1948)

***** "A medical service is only as good as the doctors who comprise it; and in order for a doctor to work to his fullest capacity, he must have security, opportunities for professional advancement and research, hospital facilities and laboratories in which he can provide for his patients the last word in medical care, and, last but not least, the pride of belonging.

"It seems to me in general, the common problems in the service medical departments are supply (I understand a common supply program has been developed in the Army and Navy at the present time and has been functioning exceptionally well for over a year), common procurement and common hospitalization. The latter, which I know has been a much debated subject, it seems to me could be solved on the basis that the branch of the service with major responsibility in a given area would assume the responsibility for high-level hospitalization in that given area, and an arrangement should be made for an inter-service exchange of specialists.

"I understand at the present time that it is impossible for the Air Force to assume a major responsibility in the hospitalization field, but I also feel very deeply that if the Air Force expects to get and retain first-class doctors they must be permitted to practice medicine as they have been taught and this must include service at the highest hospital level. Good doctors, except in rare instances, will not be content to narrow their activities to aviation medicine and the dispensary level of practice. Specific problems of aviation medicine are well understood; high altitude flying, diet as it relates to flying, air evacuation, and a multitude of problems in aviation physiology, selection, retirement, etc." *****



L. E. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr Col Harry G Armstrong, MC, 16 April 1948)


**** "1. Hospitalization and Evacuation Policies Within the Zone of the Interior With Special Reference to Construction, Distribution, and Staffing of Military Hospitals.

(1) Defects:

- (a) Failure to use air evacuation to its utmost.
- (b) Hospitals located for political reasons rather than military necessity.
- (c) General hospitals over staffed, especially by Dental Officers.
- (d) Modern planning and construction not used; i.e., air conditioning.

(2) Remedies:

- (a) Exploitation of air evacuation.
- (b) General hospitalization based on geographical needs. (13% military population from New York area and less than 1% general hospital beds in same area.)
- (c) Hospitals located near air transportation facilities.
- (d) Use modern hospital designs and equipment." ****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr Alfred W. Eyer, Captain (MC), USN, 17 April 1946)

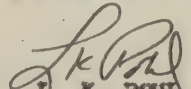
****(1) Hospitalization and evacuation policies within the zone of the interior with special reference to construction, distribution, and staffing of military hospitals.

Hospitalization and evacuation policies within the zone of the interior should envisage possible or probable attack on continental United States. Refer to paragraph 1 (a).

In general, it is believed that all future construction should be restricted in size (2000 to 4000 beds) and should be well dispersed with access to good lines of communication and supply in east and west central United States. Further, planning should envisage total utilization by both military and civilian of existing area medical facilities.

There is no particular requirement seen for joint staffing of continental activities. However, units situated in the zone of communication should be jointly staffed to enable maximum efficient collaboration between the services.

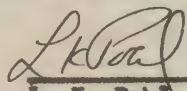
The development of underground facilities for regular wartime hospitalization is not believed feasible from the standpoint of patient care, or practical from the standpoint of expense.****


L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee, dated 18 April 1948)

*****(1) Hospitalization and evacuation policies within the zone of the interior with special reference to construction, distribution, and staffing of military hospitals.

"A few great medical centers should be established in favorable climatic areas to which most of the patients should be brought by air. A regular jitney run of air evacuation teams every morning could gather the patients from outlying stations and deliver them to the medical centers and take back convalescents on the outgoing trips. These centers should have a consultant staff of older distinguished civilian experts on a part-time basis plus recognized military specialists. The centers could be used for the training for board qualifications of younger doctors and service there would be made as attractive as that in any civilian hospital. These centers would be centers of research and could actually be the site of governmental medical schools relieving the tremendous pressure from prospective medical students which exists at present."****


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 22 April 1948)

***** "(1) Hospitalization and evacuation policies within the zone of the interior.---The plans for the psychiatric wards in our army general hospitals were antique, constructed in great excess of the needs and the hospitals were unequipped to give the modern psychiatric care to the patients. Towards the end of the war we did get "social therapy" buildings added which provided for occupational therapy and limited recreational facilities. Specific recommendations have been made by the neuropsychiatric consultants to the Surgeon General of the Army with regard to the staffing of hospitals with this group of specialists. Many of the tables of organization should be radically revised.

Perhaps under this head certain other points should be made. The promotion policy was grossly inadequate. Medical officers and enlisted men were often "penalized" in relation to other branches of the Service. This may have been related to the fact that very often they served under line officers who were limited in their ability to make promotions because of rigid table of organizations. Far too often promotion was based upon the table of organization plus the length of service and personal relationships to the commanding officer (politics). Rarely were they based upon the quality of professional work or the ability of the individual.


Many regulations and their frequent change, along with command rigidity of attitude, worked in the direction of interfering with the use of good medical judgment. One of the results frequently was a considerable reduction in medical initiative.

We can't fail to recognize that frequently there was discrimination against medical personnel on the basis of race or religion. If we expect Negroes and Jews to come into the army and navy then we have to treat them on the same basis of anybody else we accept in the army or navy.

Assignments to tactical units and undesirable posts were often based on personal feelings of the commanding officer with a total disregard for the requirements of the job or the skills of the individual.

Certainly the army, and I am not familiar with the navy, has to revise its system of disposal of inefficient and non-effective officers. Within the medical corps it was always a matter of trying to find the place where a man could do the least harm because we had no system of getting rid of him.*****

RESTRICTED



554

L. K. Pohl, Colonel, MC

RESTRICTED

EXTRACT FROM INTERVIEW WITH COLONEL W. D. GRAHAM, MC, USA, ON 11 MAY 1948
AT 2:00 p.m.

1. Was the regional hospital effective for ZI origin cases in World War II?

A. On the regional hospitals I think for planning purposes it is essential that general hospital care as we define it, in the Army, had to be statistically -- the flow of patients had to be statistically evaluated on ZI and overseas. *****

2. Is specialization of general hospitals effective?

A. The regional hospital was supposed to render general hospital type care to general medical and general surgical cases. In the event that there were in the ZI any specialized cases arising they would not go to a regional hospital. They would go to a specialty center in the general hospital.

Q. In any future emergency when should this specialization become effective?

A. Specialization is still in existence in our general hospitals. As I conceive it, the specialties that centers will operate for from now until the next emergency will gradually be reduced in number until we have only medicine, surgery, etc. T.B. will continue and probably we will have an armed forces T.B. center. We will lower the number of specialties for which we reserve beds until the thing begins to be an emergency again and when it does we will begin to delegate certain beds as vascular, etc., and they won't be returned to full specialization until the load becomes heavy enough.

3. The policy of locating general hospitals is open to criticism. Does the factor of patient being close to home outbalance the desirability of the advantages of climatic considerations which might enhance convalescence and promote economy?

A. - In all instances of which I know that climatic conditions might be better for the patient the centers have been passed in those climatic conditions. From a medical standpoint they should be put where the hospital has the best climatic conditions for rehabilitation.

RESTRICTED

RESTRICTED

(1)

EXTRACT FROM INTERVIEW WITH COLONEL W. D. GRAHAM, MC, USA, ON 11 MAY 1948
AT 2:00 p.m. (Continued)

4. What is the maximum size you recommend for the ZI?

A. - I don't think it makes any difference. To elaborate on that, I don't think it remains one hospital beyond, from my own experience -- 1500 beds. The general feeling is from 750 to 1000 if you could control it yourself.

Admiral Anderson: Do you have the same opinion about hospitals during peacetime?

A. - No, they should be limited to around 1200 to 1500 - would be the maximum. The reason for the difference is that you don't have the morale during peace that you have during war, therefore you have to look into details more closely than you would during a war.

5. Should convalescent facilities be separate or parts of each general hospital?

A. - Convalescent facilities should be inherent in every hospital. The convalescent facilities should probably remain under the control of the medical authorities by being established in hospital centers rather than as a part of a general hospital.

6. Should long-term cases be discharged to civilian institutions for final care at Government expense? Veterans Bureau hospitals?

A. - Provided adequate facilities and personnel are available in the Veterans Administration or in any other institutions to give them acceptable care and meet the high standards it is essential long term patients should be offloaded from the military medical set-up as soon as possible.

7. Should civilian consultants replace military medical specialists in localities where the former are available?

A. - If in the future the civilian consultant, whether in uniform or out, is clearly responsible to a medical officer of the services for implementing his recommendations the answer to the question is yes.

8. Is the sprawling type of construction for general hospitals advisable? If not, what is the solution in the face of critical material shortages? Does the design now used need modification? What are its weaknesses and objectionable features?

RESTRICTED

RESTRICTED

EXTRACT FROM INTERVIEW WITH COLONEL W. D. GRAHAM, MC, USA, ON 11 MAY 1948
AT 2:00 p.m. (Continued)

A. - I think Burton or Tyres on construction and design should answer that.

9. Who should control general hospitals in the ZI? Should area control under line officers or under deputies of the Surgeon General be set up geographically?

A. - The Surgeon General should have technical control in a manner similar to that established in the general order of the Navy where there are four types of command. Military command should be in the area commanded and not under the Surgeon General and should be a senior medical officer representing the Surgeon General of whatever force is concerned and he should be consulted in matters involving the medical service. He is attached to the staff as the Surgeon General is attached to the staff. ***** This should be done. I have urged the adoption by the Army of a general order clearly defining the concept of command and its division into four major portions as outlined in Navy General Order No. 245 of 1946.

10. To what extent can the partially physically handicapped, both officers and enlisted men, be used to staff hospitals in the ZI? Can greater use of female doctors be made in ZI installations? Can WACs replace enlisted males to a greater extent? Do you favor the Nurses Aid program as established during World War II?

A. - As long as the handicap is not above the ears we can use them and we can use them overseas also. Regarding the use of female doctors -- I happen to know quite a bit about them because I had an orientation group at Lawson General Hospital. Greater use could be made of them, that is to say, they could be used in greater numbers, but because of limiting factors they have to be integrated into the service with definite reference to the percentage of female personnel who might be patients. Re WAC - yes, we can use more WAC's. I don't know much about nurses aid.

12. Are debarkation hospitals necessary? In atomic bomb target areas what is the solution to the location of such installations?

A. - I think debarkation hospitals are necessary. I think that the more elaborate the facility is made and the better it is staffed the less likely it is to serve its function properly.

RESTRICTED

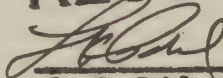
RESTRICTED

EXTRACT FROM INTERVIEW WITH COLONEL W. D. GRAHAM, MC, USA, ON 11 MAY 1948
at 2:00 p.m. (Continued)

12. - A. - I think the same precautionary measures on these installations have to be taken as they have on debarkation. If an atomic bomb is going to drop on that port, you better move the port before it drops.

13. Were there too many frills and luxuries in our hospitals which adversely affected the desire of soldiers to return to a duty status? If so, what can be eliminated? Was the policy criteria for return to duty status too high in view of manpower shortages?

A. - Yes, it affected the desire of the soldier to return to duty. Nothing can be eliminated without a major change in national policy. From a military standpoint it is probable that many patients could have been returned to gainful occupation as distinguished from military duty. Whether the line commander would accept them when they were sent back to duty is questionable.

RECORDER

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

Extract of Statements made by Brig Gen Robert C. McDonald, M^A, USA (Retired),
21 April 1948, before the Subcommittee on the Employment of Military Medical
Resources-

****"On the subject of "Hospitalization and Evacuation Policies within the ZI with
special reference to construction, distribution, and staffing of military hospitals.

"Construction of station and area"-- that is regional-- "hospitals will be
required to serve ZI posts, camps and stations," where they are. We have simply got
to follow the combat troops or the line of the armed forces and establish hospitaliza-
tion wherever required for the less seriously ill and slightly wounded.

Now, the "Construction of general hospitals should be kept to minimum through
use of existing Federal hospitals, and existing buildings, such as resort and other
hotels, and public buildings. The distribution of station and regional hospitals
is governed by the location of troops which they serve. General hospitals should
be located in accessible areas, generally near population centers, so the wounded
may be hospitalized near their homes. Convalescent hospitals should be estab-
lished in resort areas where climatic conditions favor recovery. The staffing
of hospitals, particularly with specialists, will always present a difficult problem.
Each hospital should be staffed so as to be able to carry out its mission. Regional
hospitals and large station hospitals should be staffed for definitive general
medical and surgical treatment. In addition, general hospitals should be staffed
to care for specialized cases. The designation of certain general hospitals as
specialized cases. The designation of certain general hospitals as special
centers will conserve specialists. The location of general hospitals near large
population centers will enable them to have specialists and consultants from
civil life assist in special work."

I think the growth of our convalescent hospital system in the last war was
largely due to the lack of beds in our general hospitals. Therefore, we sought to
expand them by establishing convalescent hospitals in favorable locations wherever
we could find them and without much reference to where the general hospitals were
located.

The ideal situation would be for each general hospital to take care of its
own convalescents, have them at their hospitals where they have been under treatment so
that the same doctors could supervise their rehabilitation. Too often they were
separated from a special staff.

For example, I had a large convalescent hospital at Daytona Beach, Florida.
There was no general hospital around there anywhere. The nearest one, I guess,
was Thomasville, Georgia, some 250 miles away. It was difficult to give the
wounded that were convalescing proper supervision. We had to put additional staff
down there in order to do that, and we had to build up the local hospital more
than would have been necessary otherwise.

The establishment of a large separate installation for the treatment of
convalescents should be, I think, the exception rather than the rule. There are
instances where we can go into a health resort like Atlantic City or Daytona or
Miami and do that thing to advantage, but I believe that that should be the excep-
tion rather than the rule. I believe we should take care of our wounded at the
hospital where they get their definitive treatment.

RESTRICTED

RESTRICTED

"Was the regional hospital effective for XI origin cases in World War II?"

I think that the regional hospital was very successful.

"The policy of locating general hospitals is open to criticism. Does the factor of patient being close to home outbalance the desirability of the advantages of climatic considerations which might enhance convalescence and promote economy?"

Generally speaking, I believe that general hospitals should be located so that the patients will be near their homes. I think it does outweigh.

"Is specialization of general hospitals effective? In any future emergency when should this specialization become effective?"

I think specialization of general hospitals was effective. It was in my service command. As to when it should begin, it should begin from the beginning, but be on a small scale. In other words, instead of having 4 or 5 specialists of one kind in, we will say, a service command, you would only have one, or perhaps one in each section of the United States. But they should be increased when the demand for them comes. They should not be set up and have the personnel wasted from the beginning.

"What is the maximum size you recommend for the XI?"

My largest one was about 5,000. That was down in Memphis. I don't think they should be over 2,000 beds.

"Should long-term cases be discharged to civilian institutions for final care at Government expense? Veterans Bureau hospitals?"

I think they should be to the Veterans Bureau hospitals, but not to civilian institutions.

"Should civilian consultants replace military specialists in localities where the former are available?"

Yes, sir: I think they can be used.

"Is the sprawling type of construction for general hospitals advisable? If not, what is the solution in the face of critical material shortages? Does the design now used need modification? What are its weaknesses and objectionable features?"

I don't think the sprawling type of construction for general hospitals is advisable? General hospitals should be established in existing buildings, in so far as practical. I have answered part of that.

"Who should control general hospitals in the XI? Should area control under line officers or under deputies of the Surgeon General be set up geographically?"

RESTRICTED

RESTRICTED

I don't think of any reason for setting up deputies separate from the service command, we will say. I think the service command surgeon general will carry out any policies and plans of the surgeon general, just as well as a separate person would. I don't think there would be any difficulty coordinating that with a service command surgeon general.

"Should the Surgeon Generals control evacuation transportation in the ZI? Did the adopted system prove efficient? If not, what changes are indicated?"

Yes, I agree that the surgeon general should control evacuation transportation in the ZI. I think it worked very well.

"Are debarkation hospitals necessary? In atomic bomb areas what is the solution to the location of such installations?"

Yes, I don't see what we could have done at Charleston without Stark. We couldn't get them out fast enough on the trains, and we had to have a place to put them. Some of them had to be redressed and put in shape. I agree that debarkation hospitals are necessary.

I don't see why it shouldn't be located near the port. We do have to take chances on atomic bombings.

"Were there too many frills and luxuries in our hospitals which adversely affected the desire of soldiers to return to a duty status? If so, what can be eliminated? Was the policy criteria for return to duty status too high in view of manpower shortages?"

I don't think that the soldiers were provided too many luxuries and conveniences in our hospitals. I don't think they were made to stay away from their work because of the kindly care they were receiving. I do think that medical officers in charge of cases should be very diligent, in estimating the condition of patients, and should give enough attention to know when he is ready for duty and getting back.

"Should care of dependents cease during war?"

I don't think that care of dependents should be stopped entirely during the war. There are many instances where the civil medical services are inadequate. They went without care unless it was furnished by the Army. I don't think we should have special provision made for providing adequate care for dependents, but I think when medical service is available and dependents need it, it should be given.

Brig Gen Martin: In the face of criticism that that was a wastage of doctors during the war?

Brig Gen McDonald: Yes, that's right, I doubt if very many doctors were engaged entirely on that work. In some large dispensaries, yes; in Washington, of course.

RESTRICTED

RESTRICTED

"Should WP cases be given an opportunity to demonstrate whether he can accept military status before he is eliminated? (figures show 600,000 eliminated on initial examination?)"

Obviously disabled should be, of course, eliminated immediately. But a borderline case should be given a trial. Too many were eliminated in World War II.

"Do you favor a reasonable rotation policy for specialists between the XI and theatres of operation? For other classes?"

I believe in rotation on a periodic basis.

"What was the greatest cause of delay in construction of hospitals in the XI? What recommendations do you have as a remedy for this deficiency?"

I think it was the scarcity of building material.

Brig Gen Martin: It wasn't planning?

Brig Gen McDonald: No, I don't think it was planning. Of course the plans were probably changed quite often. But I would think the main delay in hospitals was the shortage of vital materials.

"Should peacetime planning provide for personnel on a reserve status to man XI hospitals? Should they be affiliated units?"

Yes, I think they should be provided a reserve status; and I agree they should be affiliated units. There may be some difficulty in getting the units built up, on this basis, since, generally speaking, they want to go overseas the first thing. But certainly it would be valuable as a reserve.

"Can we at this time plan for locations of XI hospitals, leaving their size for later decision?"

I think that suitable locations for XI hospitals should be selected in time of peace, but that a great many more than are required should be selected so that we will have some elasticity in locating them when the necessity comes.

"Should general hospitals be separate posts with complete control over all maintenance, post housekeeping, etc.? If not, do you favor a line command for those services?"

I'd like to have them at separate posts to keep control over maintenance. You get along better that way.

"Were doctors used too much on administrative positions in XI hospitals? If yes, on what jobs? Could MSC personnel relieve them?"

Yes, I've answered that.

"Did the Engineering Corps fulfill its responsibilities in the construction and maintenance of medical facilities during the war? If not, where did they fail? Was it the result of attitude or shortages of engineering personnel and

RESTRICTED

RESTRICTED

materials? Do you agree that there should be a separate section in the Engineering Corps in peace and war for hospital construction?"

So far as I know they did a very good job in construction of hospitals. But I didn't have definite knowledge of that until practically all the hospitals were completed.

"Do you consider the administrative difficulties of operating joint service hospital facilities the paramount objection for combined use? If non-medical, widely differing administrative requirements of the Army, the Navy and Air Force were rectified by adoption of an identical administrative system (same forms, laws, etc.) would joint use of facilities be feasible?"

My answer to the last part of that question is "yes."

I think they ought to get together and have the same list.*****

RECORDER

L. K. POHL
L. K. POHL

Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Extract of statements made by Colonel Thomas J. Hartford, MC, USA on 23 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

***** "1. I agree that there should be a separate section in the engineer corps in peace and war for hospital construction. The most valuable group that I can think of in the theater--and I blessed them many times--was a hospital design team; a group of generally soldiers who had had experience in hospital construction, and the engineers as they went along, especially in the communications zone, got better and better in constructing and doing over concerned and making them into hospitals, and I became an engineer convert. I thought they were pretty good. And each time they built a hospital it was better, and when they were able to go into the German prisoner war camps and pick out really skilled artisans, why it got still better. But when the war was over and I found myself in the Army with some fine fighting engineers of the Third Army, I found out that even I was a better carpenter than most of them. They couldn't build anything. They didn't have the slightest idea; and they tinkered around for weeks in my area trying to reconvert some concerns to hospitals, and until we got two or three hundred prisoners in each one of those places why you couldn't even tell what they had set out to do. *****

RECORDED

L. E. Pohl

L. E. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 Apr 48.

***** I. "The physical set-up of our installations has much to do with the amount of personnel that is needed. Although bed-patient load might be reduced one month or for a period of months, that doesn't mean wards and clinics close, and we still have the same amount of area to cover. You can't do proper nursing work if you are going to spend your time walking back and forth just to cover an area to see what is going on.

I'd also like to see authorization for employment, in hospitals, of personnel for housekeeping duties, probably with civilian housekeeper in charge, which would result in better housekeeping maintenance and would relieve ward personnel who should be available in assisting in the care of a patient.*****

L.R. POHL
L.R. POHL, Colonel, MC

TRUE EXTRACT COPY (Ltr Brig. Gen. G.R. Kennebeck, Dental Corps, dtd 7 May 48)

***** I. "In the Zone of the Interior buildings designed for the purpose should be constructed in a central location and each military installation and all available dental personnel concentrated therein. Such an arrangement results in more efficient operation. It will be necessary for a few dental officers to be on duty at each station hospital for the treatment of patients. However, most dental treatment is given on an out-patient status and therefore the larger dental installations need not be operated in conjunction with station hospitals.*****

L.R. POHL
L.R. POHL, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. RENDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** "8. Sprawling type of hospital is not advisable.

"9. Area control. I don't believe so. General hospitals should be under the control of the Surgeon General.

"10. To a considerable extent. Greater use of female doctors could be made. WACS could replace males around the hospital to a great extent and they make better nursing assistants. Nurses Aid - yes. I am very much in favor of the WAC hospital company."*****

RECORDED

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Letter from Colonel Richard T. Arnest, Ret.
dated 19 April 1948)

**** "1. In the zone of the interior insofar as is practical, construction should be of a permanent nature. Such hospitals should not be released from federal control but released to veterans or to states on a loan basis to be available in case of future need. Distribution of hospitals - they should be adjacent to or on cantonments - in the near vicinity of ports but removed from large cities. Hotels are not readily adaptable to hospital use. Cantonment type hospitals should only be utilized as a last resort and abandoned as early as practical. Staffing of Zone of Interior hospitals must always be in accordance with needs. The surgeon on the spot should best know his needs but must be watched or he will overstaff. Specialized Hospitals should be continued and staffed accordingly." ****

RECORDED

L. K. Pohl
L. K. Pohl
Colonel, U. S. Army

TRUE EXTRACT COPY (Ltr fr N. C. Mashburn, Col., MC, 19 April 1948)

*****"Large hospitals serving areas is most efficient and economical. However, medical personnel caring for individual units must not be completely separated from the sick. Some compromise plan is recommended."*****

RECORDED

L. K. Pohl
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M. J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

***** "(1) Hospitalization and evacuation policies within the zone of the interior with special reference to construction, distribution, and staffing of military hospitals.

My comment here must be limited in accordance with the extent of my first-hand knowledge and experience. I served in two such hospitals which were well-constructed, well-located and well-staffed and which were employed to full capacity yet met all demands that were made upon them.*****

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

***** "(I) Hospitalization and Evacuation Policies Within the Zone of the Interior with Special Reference to Instruction, Distribution and Staff of Military Hospitals.

The only comment in this connection is as follows:

It is believed that many military hospitals in the Zone of the Interior early during World War II were staffed with doctors who were never made available for overseas duty. There was doubtless a hiding under the guise of limited duty of many who had relatively insignificant physical defects and were kept at home only because their respective Commanding Officers cried loud and long when movement of such personnel was anticipated. A system which permits this is defective and correction must come from the higher levels.*****

TRUE EXTRACT COPY (Ltr Colonel Robert P. Williams, MC, Surgeon, dtd 16 Apr 48)

***** I. "Hospitalization and evacuation policies within the zone of the interior with special reference to construction, distribution, and staffing of military hospitals. Hospitalization within the Zone of the Interior should be on basis of the service (Army, Navy, Air) as far as station hospitals and dispensaries are concerned. Each hospital to care for members of other services as at present. All general hospitals should be based on the unified policy. Concurrence of the Surgeons General or failing that, decision of the Secretary of Defense should determine which service has paramount interest in a given locality. That service should then furnish general hospitalization for all services. The commander of the hospital should be from the service having paramount interest, his executive from the opposite service. The hospital should be staffed by Medical Department officers of the several services in approximately the proportion that the patients come from from the various services.

RECORDED
L.K. FOHL
Col, MC

TRUE EXTRACT COPY (Ltr Brig. Gen. Guy B. Denit, MC, Surgeon, dtd 18 Apr 48)

***** I. "Hospitalization and evacuation policies within the zone of the interior with special reference to construction, distribution, and staffing of military hospitals - We should never again go back to Civil War construction. Hospitals should be located with a view of their postwar utilization.*****

RECORDED
L.K. FOHL

L. K. Fohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C.B. Cameron (MC), U.S.N.,
Retired dated 21 April 1948)

*** "(1) The outstanding point in this connection appears to be in the provision for evacuation from Receiving Activities and Hospitals, etc., on the coasts concerned - or other points of entry to the homeland - to points further inland as rapidly as possible, for in the face of heavy casualties, the receiving points quickly become over-loaded and proper care of patients diminishes in direct ratio. Ample and continuous transportation well into the interior to previously prepared centers, thus taking the load off the receiving centers is of vital importance and its neglect invites disaster." ***

L. K. Pohl

L. K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

**** "1. It should be the policy to hospitalize any patient from any Branch in any hospital. The procedure and forms for reporting should be uniform in all hospitals of all Branches. It should be a general policy to evacuate patients to hospitals of their Branch, although this should be very elastic, depending upon the nature of the individual case, i.e. cases definitely due for long periods of hospitalization or disability discharge should be sent to hospitals near their homes. Cases needing specialized treatment to specialized hospitals, etc.

"Hospitals should be of uniform construction for all Branches. General hospitals should be distributed according to civilian population centers, with only evacuation and station hospitals in the communication zone. All evacuation and general hospitals should be located near the airport. Hospital commanders should be medical officers with free use of Medical Service Corps officers as executives and administrators. Professional Staffs should never be placed under the direct administration of other than a medical officer." ****

RECORDER

RESTRICTED

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel O. F. McIlnay, MC, Air Force
dated 20 April 1948)

***** "1. Hospitalization and evacuation policies within the Zone of Interior were not observed by the undersigned. However, it is understood that there was much wastage of professional personnel due to their being assigned to duty at Hospitals when their services were not yet required. Reorganization of the Medical Department organizations suggested in paragraph f above would make it unnecessary to order such individuals to these hospitals until such time as their services were actually required. Construction and distribution of hospitals in the Zone of the Interior as elsewhere will be dependent upon the type of warfare, but it appears that they must be properly dispersed and that they should not be located in the near vicinity of large cities, ports, industrial areas, or other military functions." *****

RECORDER

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr M. C. Stayer, Major General, U. S. Army, Retired, 18 Apr 48)

**** "(1) Hospitalization and evacuation policies within the zone of the interior with special reference to construction, distribution, and staffing of military hospitals.

It is my belief that the Theatre Surgeon should have more to say in the construction, distribution and staffing of military hospitals than was given him in the past. Hospitals were forced on me that were expensive, and, in my opinion, were not properly designed. Hospitals were built in the Canal Zone by the Army as permanent installations with little regard to the needs. The medical personnel in the Canal Zone were asked to give little advice and when given, the advice for the most part was ignored. The Army, Navy, and civil authorities built hospitals near each other, and the Air Corps would have also built, if possible, in the Canal Zone. This was, and is, a marked picture of the lack of coordinated effort and caused great duplication of construction, personnel and material."****

RECORDED

L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED**EXTRACT OF STATEMENTS MADE BY:**

Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

***** "(1) 6. I think yes. I think that the mission of the medical department of the Army or the Navy or the Air is to take care of those major forces and not take care of people who aren't now or expected to be in the near future active members of those forces. Therefore, I think they should be put in the Veterans' Bureau hospitals.

"I think that it is feasible and desirable to utilize civilian specialists in Zone of the Interior hospitals in consulting capacities, in professional capacities, and teaching capacities. I feel that that is the place they should be used.

"(I) 9. I can tell you who is going to control. The Surgeon General should control all hospitals in the ZI.

"(I) 10. I think that physically-handicapped officers and enlisted men can and should be used in staff positions in ZI hospitals, and I think that certainly in wartime greater use can be made of female doctors in ZI installations. That is entirely compatible with my statement a moment ago that I don't think the women should be in the combat zones. I don't know about WACs replacing enlisted males.

"Definitely in Z I hospitals. In ZI hospitals, yes. I think if you can keep your women in the ZI and let your men go to war, you are going to have better results."*****

"(I) 11. I do think that the surgeons general should control evacuation transportation in the ZI. I am not familiar with the system adopted and can't answer the rest of the question."*****

"(I) 15. I saw thousands of cases of suspected psychosis, or at least psychoneuroses, who were condemned without trial and thereby made worse; particularly in the Marines. The minute a man in the Marines was suspected of being a neurotic or psycho, or something, his commander or platoon said, "You are not fit to be a Marine any more," and that made more MPs and the thing just snowballed. I think from a personal stand-point this is not an expert opinion—that they should be given a trial."*****

RECORDER

L. I. Pohl
 L. I. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

Extracts of Statements made by Brig Gen Robert C. McDonald, MC, USA (Retired),
21 April 1948, before the Subcommittee on Military Medical Resources.

****"Hospitalization and Evacuation Policies within the Combat Zone, and evacuation to the Communications Zone and to the Zone of the Interior."

"Hospitalization in the Combat Zone should be in mobile medical units and should be of short duration."

We started into Australia and into the Southwest Pacific with the idea we were going to have to put up lots of prefabricated buildings, and it would have been a grand thing if we had had those ready, but I think that part of the war was about over by the time we did get them over. I didn't go over to the theater very much, but I suspect they weren't ready.

I do think we should have prefabricated buildings ready in time the next time, because they are of very great advantage in the tropics. I think the Navy, from reports I received, were ahead of us in that respect. They did have better provision for their mobile hospitals, small ones, than the combat area.

I think that the Division area, for example, up near the front, really shouldn't try to hold patients more than two or three days. In maneuvers and in combat in the first world war, I found that was impracticable if you are getting very many wounded and sick. You would have to clear those units because they have to be kept mobile and back in the Army area in time of active combat two weeks would certainly be a maximum, or in the case of a badly wounded man who had no prospect of returning to the front lines soon, or a seriously ill man, return him to the rear as soon as he was physically able to stand the transportation.

Regarding the policy of evacuating to the Zone of the Interior, I think that depends so much upon the situation; that is, the size of the war, the nature of it, the strength of the enemy, the lines of communication, and the distance from the home territory, and so on, it's very difficult to determine that.

I think that we first started out in the world war to go on a 90-day policy, and I think some of our patients from India got to San Francisco about the end of the 90 days and were ready to turn right around and go back, and they did get well, and that was too short, of course, a time for a theater like that.

On the other hand, I believe it was General Hawley's policy in England to retain his people six months. That was before the active combat started, however, during the assembly and mobilization of the force for the attack on Europe, and it apparently worked all right. It did enable him to build up hospitalization which would be ready for the peak load when it did come, which I think was a very fortunate thing; but somewhere from 90 days to six months is probably the zone for retaining patients in the communications zone or in the theater of operations.****

RECEIVED
L. R. POOL
Colonel, MC
RESTRICTED

RESTRICTED

Extracts of Statements made by Brig. Gen. Robert G. McDonald, MC, USA (Retired)
21 April 1948, before the Subcommittee on the Employment of Military Medical
Resources.

*****1. "I think the general hospital of a thousand beds we had something like 43 medical officers, plus a large number of medical administrative officers and dental officers and others, making a total of perhaps over 60. We found out later that wasn't necessary, that perhaps half of that number of medical officers could do the essential professional work, turning over to nonmedical personnel as much of the administrative and routine work of operating a hospital as was practicable.

"The specially qualified personnel available had to be spread thin enough to man all organizations" in the later stages of the war. "Medical equipment was adequate in most organizations. The development of special equipment for jungle warfare was outstanding. The development in peacetime of special equipment needed in Arctic climates is most valuable and timely. The training of Medical Department Personnel was well organized, and generally well done. The tactical employment of Medical Organizations was well planned and carried out;" as far as I know. I did not serve in a combat zone.

The handling of the sick and wounded brought back from Europe in the later stages of the war was well handled. In the Fourth Service Command we brought most of the badly wounded and seriously ill patients - that is, litter patients - in to Charleston, and from there in the hospital unit trains operated by the Office of the Surgeon General they were very expeditiously distributed to various hospitals. There did develop a great difficulty because of the distribution of our general hospitals; namely badly wounded patients who were later to be discharged from the service could not be hospitalized near their homes.

There was a policy early in the war, when we were afraid the Germans, or somebody would be bombing over here, established by the War Department of not building general hospitals close to the Coast.

I was Surgeon of the Third Service Command over here at Baltimore in 1942, and I found I was terribly crippled by that. We had lots of population, but very few general hospitals. I made strong recommendations that they abandon that policy and build hospitals along the Coast where they were needed, the most, and they did do that in my own Service Command. They established one out here in the Shenandoah Valley and in Richmond and at Philadelphia and Pittsburgh. We did finally get a chain of hospitals.

I don't believe that we can base our distribution of hospitals on any such basis as that. It may readily be seen that they perhaps should not be in the middle of great centers of population, but certainly they shouldn't consider the Coast as so vulnerable that we can't put any hospitals anywhere near it.

The medical units for the communications zone, particularly for the combat zone, should have supplies and equipment to enable them to carry on for a reasonable period. That depends, of course, upon the location of the theater, upon the nature of the warfare, upon the strength of the enemy, and various other factors; but certainly as a general rule I think something like 30 days of expendable supplies for a combat unit would be reasonable tin going into the theater, and another 30 days, perhaps in the Army area, and then into communications anywhere

RESTRICTED

RESTRICTED

from 60 days to four months or even six months, depending upon the security of the line of communications and the combat situation.

"In general, did medical department units and organizations have sufficient personnel? If not, how was the deficiency corrected by you? Have you any specific recommendations for particularly inadequately staffed units or facilities? Were your observations based on peak loads or emergencies or on so-called normal loads?"

It applied to my units down there. I had a great shortage of personnel, enlisted personnel in general hospitals, in large station hospitals. It was met by assigning prisoners of war on duty; and they did splendid work. In fact, we couldn't have gotten along through the early stages of the demobilization without them, because we did not have enough personnel to carry on.

"Do we need any new medical units? If so, for what specifically? What is the basis of your recommendation?"

I can't comment on that. We may need units, but I don't know just what they are and what they should do. We certainly are developing new ways of warfare, and it is probably going to call for new types of units. But I don't know what they are.

"Did our planning figures allow for enough medical department units in any given task? Should we revise our planning data for medical cases in forward areas? Atomic warfare?"

"Didn't have knowledge of that situation. I think, generally speaking, that when we organized a task force or tried to set up equipment for a war plan, that enough stuff was sent over there probably to cover it. But in its distribution over there, I don't know what the situation was, or what the situation was after the expansion. My comments wouldn't be worthwhile.

"Did the presence of females in medical field units prove worthwhile? Necessary for professional reason? For psychological reasons? Should be increase the female component in our field and fixed units wherever possible? Did females hamper the movement of units? Did they reduce the mobility of units because of their necessary separate accommodations?"

I don't know about that.

Brig. General Martin: I'd like you to answer the last part.

Brig. General McDonald: The Vacs did excellent service in my service command.

Brig. General Martin: The question is - should we increase the use of females?

Brig. General McDonald: Not in the combat zone.

Brig. General Martin: You have had experience in a fixed zone?

Brig. General McDonald: Yes, we can use more females".*****

RESTRICTED


L. K. POHL, COLONEL, MC

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USN
4 May 1948.

***** I. "REAR ADMIRAL ANDERSON: Now as to that same subject in regard to the Continental United States, would you discuss it with particular reference to the construction of hospitals and the distribution of hospitals and their staffing?

One question that has come up is who should control the evacuation and distribution of patients inside the Continental United States? In our Service it was the Bureau of Medicine and Surgery that controlled it. I mean, who should control it between districts?

REAR ADMIRAL WILLCUTTS: There again, with total war and with key points destroyed or exposed, I believe that this distribution will have to be decentralized. I believe you cannot depend upon one bureau to direct an overall hospitalization. Somebody should have a clearing record, a clearing zone, so we may know where there are empty beds. But our country is so large that I believe, if possible, we should make a distribution center, say, at least 3 or 4 zones - say, west of the Rockies, and the Mid West. Against that, of course, comes the sentiment that they want the boy near the hospital where he lives. That was the basis of Med and Surgery, not so much as to getting them into beds as it was to get this kid near his grandmother or his mother. It became the law that any boy could go to a hospital near his home. That was a luxury of the first order.

REAR ADMIRAL ANDERSON: Do you think the advantages of transferring a patient to a hospital near his home outweigh other considerations like climate, particularly climate?

REAR ADMIRAL WILLCUTTS: No. I think that has very great disadvantages - this sending of a boy to his home. He has to break apron strings; he is not the fighter he was for weeks; he softens up when he goes home. To fight you have to be brutal; you have got to be rough. And when you put this boy home, he sees his family, his preacher and all the nice things - shiny cookies - and they soften him up. If you could keep him away until the war is over, you would have a better soldier, a better fighter, and a better sailor. That was pure sentiment that brought those boys to their homes, not efficiency. It was a great morale builder.

REAR ADMIRAL ANDERSON: What do you suggest as to the ideal size of a general hospital or Naval hospital?

REAR ADMIRAL WILLCUTTS: When you go above 500 to 1000 beds, you are getting into a very, very big operation. I think a 1,000 bed hospital can be considered a military hospital.

REAR ADMIRAL ANDERSON: Do you feel that specialized hospitals, hospitals for the treatment of similar types of cases - is justified?

REAR ADMIRAL WILLCUTTS: Then you trespass through the training program. These people must be trained. You have got young doctors, and they should have general training. It is difficult to put all your orthopedic cases in one hospital and heart cases in another. I think a general hospital should be still a general hospital with a variety of cases. The clinical material should be kept there for training as well as for the general morale building of the staff. I do believe in the late stages for deafness and blindness, and these highly specialized cases, they certainly should be segregated. The amputees, I think, were handled all right.

RESTRICTED

RESTRICTED

TRUE COPY EXT. OF INTERVIEW WITH REAR ADMIRAL MORTON DL WILLCUT (MC) USE 4 May 48
1. CONTINUED:

REAR ADMIRAL ANDERSON: Do you think convalescents should be cared for in general hospitals or in convalescent hospitals?

REAR ADMIRAL WILLCUTTS: There again, I think your convalescent patients should help out in the hospital. I can't think of any finer occupational therapy than a patient helping himself and his buddies. To have a patient go in and get his medicine and get his dressing and loaf all day and perhaps do some fancy belt wearing, or what not, for some pretty Red Cross artist, is, to me, not practical. I think the convalescent patient could be utilized in the general hospital to help, to do lighter work, to clean up, to do a great share of the ordinary work that comes along with a busy hospital. You can't have civilian employment to the extent of doing all this, and your hospital corpsmen is relieved of a lot of that work to do bedside work. There comes a day, however, when a convalescent has developed to a stage of advanced convalescence, where perhaps a psychoneurotic, or someone having something, pertaining to asthenia, where it takes him many months to correct it, then he probably should go and be restored to fighting fitness by specialized convalescent hospitals.

REAR ADMIRAL ANDERSON: Do you think it is practicable to plan the distribution of hospitals for the next emergency now?

REAR ADMIRAL WILLCUTTS: I think we should consider specialized weapons in planning. I do believe that our hospitals in the peripheral cities will be better located than those in the center. I think hospitals should be planned, based upon known factors that we have today.

REAR ADMIRAL ANDERSON: Should we plan on what are called debarkation hospitals in the vicinity of ports?

REAR ADMIRAL WILLCUTTS: The ports are congested. I think, if possible, one should have his hospital a considerable distance away if he can make good contact. You must have a port, for a ship can't come on land. But to have your big hospital in that port area close up just makes for congestion. Ideally I think they should be inland to a point of removing the congestion incident to the movements of other logistics than sick people.

REAR ADMIRAL ANDERSON: What about the staffing of military hospitals?

REAR ADMIRAL WILLCUTTS: I have very definite ideas about staffing of the hospitals. I think staffing should be, if possible, kept peculiarly Service. That is, if it is a Naval hospital there is no reason why they should not have any type patient there, but, if possible, the staff should be all Navy; in an Army hospital, the staff should be all Army. You are going to have difficulty, I fear, if you try to mix up the staff.

The doctors manning a big general hospital should be of one type. After all, when you get the patients in the hospital, the patients will be treated on a standardized basis. But when you come to the command, to the sequence of military medicine, there I fear it would be confusing. By that I mean if you have a mixed crowd - a Naval commanding officer and an Army chief of surgery or executive officer whereas they could certainly be friendly and cordial, it would be confusing. I think we should have individual service staffing.

RESTRICTED

RESTRICTED

THIS COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USN
4 MAY 1948, 1 CONTINUED:

REAR ADMIRAL ANDERSON: Do you think the Nurses Aide Program worked out satisfactorily?

REAR ADMIRAL WILLCUTTS: Yes, I think Nurses Aides were helpful when properly supervised. They had to be supervised. The ladies did a grand job, a grand thing. The Red Cross did a grand job, as did these various other categories that came along. But there again you get a lot of sentiment, and you have got to know how to handle them based upon a lot of patience and tolerance.


REAR ADMIRAL ANDERSON: Do you feel that the WAVES were successful assistants in the Naval hospitals - and would you increase the number of WAVES in the staff?

REAR ADMIRAL WILLCUTTS: I think the WAVES did a magnificent job in the war. The term WAVES means Women's Auxiliary Voluntary and Emergency Service. They did that. They filled that bill splendidly. I do not think, however, they should be a permanent component of the Regular Service. I think they should be kept in the Reserves. I do know in the hospital they worked like a brother and sister to our male corpsmen; and it was a very wonderful performance. They did a great job. At San Diego I had at one time 1,100 WAVES at my hospital.

REAR ADMIRAL ANDERSON: What are the objections to the WAVES as a permanent part of the medical service?

REAR ADMIRAL WILLCUTTS: In the Navy we have rotation of billets, of jobs as you know - sea duty and shore duty. We have rotation of favored billets. By favored billets I mean staff billets - yeomen billets, clerical billets, in addition to the professional billets such as the technicians. The WAVE technicians were excellent. The female on that side is better than the male, that is, at the bedside, but we have got to have male attendants at sea and overseas, in the rough places. And if you deprive this hospital corpsman of these technical billets and these favorite billets, such as clerical and secretarial positions, they must learn administration and they must learn to do staff work - that interferes and I am fearful of a reversal of sentiment towards the WAVES by our enlisted men in peacetime.

REAR ADMIRAL ANDERSON: Are there any farther questions on this? (None)


L.K. POHL, COLONEL, MC

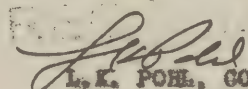
RESTRICTED

RESTRICTED

ABSTRACTED FROM PERSONAL LETTER TO COL. L.K. POHL, MC FROM COL. E. BURSQUIST, MC,
DATED 19 May 1948.

***** I. "Another policy which should be changed in the General Hospital Plan, is the one which requires patients to remain in hospitals for periods long beyond the time required in civilian life. The resulting increase in hospital bed requirements, makes this a very expensive policy, requires much supervision on the part of trained Medical personnel causes a breakdown in morale of the patients, due to the feeling that they are still hospitalized awaiting Board actions, and makes Medical officers annoyed at looking at the same faces long periods of time. A system of transferring patients in command control, immediately they are well, should be set up in all hospitals. The old-fashioned idea, originating in the Infantry and Cavalry, of keeping in the hospital until he can ride a horse, is obsolete. There is no reason why, in a technical Army or Air Force, a man in a cast can't sit at a desk or machine and perform certain functions.

Another big error was the over-construction of hospitals. The ~~4~~ figure is excessive and expensive. Modern chemotherapy, early ambulation, and a system of quick return to command control, should save billions of dollars in hospital construction.*****


L.K. POHL, COLONEL, MC

REPRODUCED FROM COMMENTS BY AIR FORCE MEDICAL DEPARTMENT OFFICERS, ANDREWS FIELD,
TO COL. L.K. POHL, MC, AS PROVIDED INFORMALLY MAY 20, 1948.

***** I. "Hospitalization and evacuation policies within the zone of the interior with special reference to construction, distribution and staffing of military hospitals. Construction - The majority of our hospitals at present are the contention type built during World War II and reflect the necessity of establishing and maintaining minimum standards for each and every department. It is believed that the minimum standards established should reflect the functional layout plans and floor space utilization proposed in "Elements of the General Hospital" prepared by Division of Hospital Facilities, USPHS. This publication reprinted from the "Architectural Record" is based on civilian requirements. There is no doubt that the military hospital with its ever present emergency role in modern warfare, must be prepared for all casualties, military and civilian, as must the civilian hospital be prepared for civilian and military casualties.

Outstanding inadequacies are: 1) OR's, clinics without adequate record rooms, dressing rooms, waiting or lounge rooms. 2) OR's with expensive explosion proof switches and spark proof electrical outlets, yet the floor is non-conductive and a potential OR hazard.

Efforts to install floor grids or conductive type linoleum are met with the comment that R & U funds have been depleted. 3) X-ray clinics - consist of the office space, exposure rooms, dark room and waiting benches usually in the hospital corridor. No provision made for the inclusion of toilet facilities, required when barium enemas are used for fluoroscopy; dressing rooms, a must with the X-ray examinations of female patients. Again efforts to make these changes result in the comment that funds are not available. (Repair and Utilities).

RESTRICTED

RESTRICTED

REPRODUCED FROM COMMENTS BY AIR FORCE MEDICAL DEPARTMENT OFFICERS, ANDREWS FIELD,
TO COL. L.K. POHL, MC, AS PROVIDED INFORMALLY MAY 20, 1948, I CONTINUED:


4) OB Clinics, delivery rooms, nurseries, etc. are improvised with minimum expenditure of funds and in many instances do not provide for: a) Explosion proof Delivery Room. b) Air conditioning in the clinic. c) Cubical techniques in Nursery. d) Formula room resulting in the preparation of formula in the ward diet kitchen.

Regardless of construction, the present standards of maintenance and the procedures of maintenance are entirely inadequate. The shortage of funds, (BAU) the methods of classifying proposed changes, installations, etc. do not lend toward efficient maintenance. There is no doubt that with the present set-up, the cost of processing the paper work on a small work project at a station hospital would and does exceed the cost of the project which, in a civilian hospital, would be dependent upon the decision of the administrator and accomplished by Hospital Utility personnel that same day.

This condition of outright dependency of the medical service on other activities or services which are controlled by non-medical interests naturally manifests itself in every department of the hospital. a) The Medical service has available funds for technical personnel which are not available through military sources but are available from local civilian sources. Personnel ceilings in effect, do not allow hiring of additional civilians so the hospital gets along without the technician.

b) The following is an extract from "On Hospitals" in the biographical note of the author, S.S. Goldwater, M.D., former commissioner of Health of the City of New York and commissioner of Hospitals of the City of New York: "To carry out his policies in a system inextricably bound up with city government entailed a constant struggle not merely against the cruder forms of favoritism, interference, and partisanship, but against hampering legal restrictions on the prompt action, delicate decisions, and flexible judgments which, to his mind, were essential in hospital work. A central purchasing bureau should not, he protested, have the power to substitute another brand of sutures for the one asked for by the surgeon; "The surgeon carries both a legal and moral responsibility and I think the City is bound to support him in the exercise of his judgment". He strongly favored the merit system, and the Department made very substantial advances in the civil service classification of its employees, but he maintained that interns should not be selected by civil service; the medical staff observes the interns at work and "for the judgment that is born of this experience there is no substitute". He contended that hospital planning should not be assigned to a general Department of Construction, for it was a logical function of the Hospital Department, which had a central and immediate interest in the construction of hospitals and had access to the advice of qualified specialists in every medical field."

It is apparent that, at present, the conditions expressed above by Dr. Goldwater closely parallel the present military medical set-up at the average station hospital.*****


L.K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH BRIG. GEN. JOSEPH E. BASTION, MC, USA, (RETIRED)
ON 3 MAY 1948.

***** I. "Hospitalization and evacuation policies within the zone of interior with special reference to construction, distribution, and staffing of military hospitals."

Well, of course, now to begin with in the last business you know they tried to set up hospitals for areas; that is, take the midwest area, that would have two; everybody would have to come there because they lived there. But due to the dearth of specialists, and so forth, that, as you know, didn't work, and it won't work, and I think that hospitals - you have got to have special hospitals, because you are not going to have enough specialists to go from Texas to the Great Lakes. Within reason you can separate them.

BRIGADIER GENERAL MARTIN: I might ask you at this point in the zone of the interior in time of war would it be feasible to use local specialists in the civilian status at armed service institutions rather than call them into service and dissipate their work?

BRIGADIER GENERAL BASTION: That could be done, yes. I wouldn't like it, but I would do it to help the over-all role in the medical phase of the whole war, whatever it is. It can be done.

A lot of things depend upon whoever the commanding head medical is in those places. No matter who you've got, no matter how good an outfit you've got under you, if the fellow isn't trained at the top to recognize all these things, you aren't going to get anywhere anyway; but that can be done.

BRIGADIER GENERAL BASTION: I don't quite get that.

COLONEL FOHL: If a man has a load comparative to that carried by civilian physicians that remained out of the service in the past war, the amount of work that he can do is limited. Therefore, if there is a selection which he must make as to what surgeries, for instances he will do, it is my feeling that he would possibly very humanly prefer the work which would give him the greatest financial return. Would such a factor operate possibly to the detriment of the adequacy of the medical service rendered by that individual?

BRIGADIER GENERAL BASTION: Yes, it would, if that happened, if you let it happen.

COLONEL FOHL: What can you do to prevent it if the circumstances exist?

BRIGADIER GENERAL BASTION: You would have to go to this pool and get one full time.

BRIGADIER GENERAL MARTIN: Now I have a question here. The policy of locating general hospitals is open to criticism. Does the factor of patient being close to home outbalance the desirability of the advantages of climatic considerations which might enhance convalescence and promote economy?

BRIGADIER GENERAL BASTION: No, it certainly does not. That is what I was trying to bring out. Climate is nice for certain things, but you will never

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH BRIG. GEN. JOSEPH E. BASTION, MC, USA (RETIRED)
ON 3 May 1948. I CONTINUED.

be able to put a general hospital, as far as I have been able to see, in a locality and have all these very high top-grade specialists do the greatest good to the greatest number. You haven't got enough of them in the country to fight the war and run these big hospitals. My answer to that would be no.

BRIGADIER GENERAL MARTIN: What's the maximum size for a general hospital that you would recommend for the ZI?

BRIGADIER GENERAL BASTION: Well, are you talking about what you think one fellow could run?

BRIGADIER GENERAL MARTIN: Efficiency.

BRIGADIER GENERAL BASTION: Between 1500 and 2000.

BRIGADIER GENERAL MARTIN: Should the convalescent facilities be separate or parts of each general hospital?

BRIGADIER GENERAL BASTION: Separate.

BRIGADIER GENERAL BASTION: Officer and enlisted personnel should have separate convalescent facilities.

BRIGADIER GENERAL MARTIN: Should long-term cases be discharged from service hospitals to civilian institutions for final care at Government expense?

BRIGADIER GENERAL BASTION: Well, now, there are a great many factors. It would depend upon the institution. If that institution were set up to take care of paraplegic cases, we will say, you can do it; but the thing you have to be careful there is the patients resent very much being sent away from the military during that time, and it should be done as little as possible. In other words, the Armed Forces should take care of their people up to the very last minute, I think.

BRIGADIER GENERAL MARTIN: Another question. Is the sprawling type of construction for general hospitals advisable? If not, what is the solution in the face of critical material shortages?

BRIGADIER GENERAL BASTION: I don't like it. You can have a system of ramps of easy rides that would take care of most of the objections, I think. Go up in the air more and save people miles of running around all day and wasting space and taking care of miles of corridors, and everything else.

BRIGADIER GENERAL MARTIN: Who should control the general hospitals in the ZI?

BRIGADIER GENERAL BASTION: It should be under part of the Armed Forces, whatever you want to call it. It should not be under the Army area Commander.

BRIGADIER GENERAL MARTIN: What is your opinion as to utilizing more fully the physically handicapped or limited-service type of personnel in hospitals in the ZI?

RESTRICTED

RESTRICTED

TRUE COPY OF INTERVIEW WITH BRIG. GEN. JOSEPH E. BASTION, MC, USA (RETIRED)
ON 3 MAY 1948, I CONTINUED:

BRIGADIER GENERAL BASTION: People have an idea that hospitals can be run by morons and any defectives that somebody else doesn't want. Their proportionate share should be allotted to any zone of the interior installation and not from the standpoint because they are hospitals.

BRIGADIER GENERAL MARTIN: Were there too many frills and luxuries in our hospitals which adversely affected the desire of soldiers to return to a duty status?

BRIGADIER GENERAL BASTION: Yes.

BRIGADIER GENERAL MARTIN: What can be eliminated?

BRIGADIER GENERAL BASTION: Off the record. Yes, they did, but one of the things that was even as bad as that, if not worse, was the desire of the civilian physicians who didn't understand the problem to hang onto these people and a hospital commander should at least once a week go out and clean house. I believe that as long as the man is a patient nothing too much can be done for that person, and he should be treated as a patient; but the minute professional opinion comes along that he is better, he should go, then there should be - that's another thing, there should be some way you can get them out in 24 hours, or 48. I think that our business of sending them from here to there and other places, what do they call those places where they send them, where a few of them went - well they didn't go back right to their units.

BRIGADIER GENERAL MARTIN: Rehabilitation.

BRIGADIER GENERAL BASTION: Yes, and several of those. They hung along the road too long.

BRIGADIER GENERAL MARTIN: What was the greatest cause of delay in the construction of hospitals in the ZI?

BRIGADIER GENERAL BASTION: I wouldn't know.

BRIGADIER GENERAL MARTIN: Would you favor at this time planning for the location of ZI hospitals leaving their exact size for later determination?

BRIGADIER GENERAL BASTION: I would, yes.

BRIGADIER GENERAL MARTIN: Should general hospitals be separate posts with complete control over all maintenance, post housekeeping, and so forth?

BRIGADIER GENERAL BASTION: Yes.

BRIGADIER GENERAL MARTIN: Were doctors used too much in administrative positions in ZI hospitals?

BRIGADIER GENERAL BASTION: Not in mine, but I knew of some where they were. That's up to the local commander, the local man in charge. That's up to the local commander. I don't see any problem there.

RESTRICTED

L. E. POHL
L. E. POHL, COLONEL, MC

585

RESTRICTED

TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA
13 May 1948)

MAJOR GENERAL KENNER: *** "As to hospitalization and evacuation policies within the ZI I have just one comment. I believe that cases that are known to have no military potential, just as soon as that is determined, should be turned over to some agency, VA, or somebody else, because they are of no use to the Army. They have no military potential, therefore why keep them for a year or a year and a half until they attain maximum hospitalization.

BRIGADIER GENERAL MARTIN: To what extent can the partially handicapped, both officers and enlisted men, be used to staff hospitals in the ZI?

MAJOR GENERAL KENNER: I believe a board should be set up to review all of the disabilities now currently listed by the VA for the purpose of determining what type of casualty may be considered as available for duty in a limited status. We have some cases of residuals from wounds that preclude the individual's assignment back to his basic arm or his assignment to certain military duties, but will permit him to perform a very useful function in some other capacity. In that way we would be able to obtain the maximum utilization of our manpower.*****



L. K. Pohl, Colonel, MC

RESTRICTED

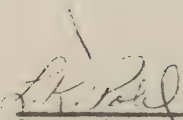
RESTRICTED

TRUE COPY EXTRACT (Letter, Captain H. D. Templeton, MC, USN
dated 23 April 1948)

***** "(I) HOSPITALIZATION AND EVACUATION POLICIES WITHIN THE COMBAT
ZONE AND EVACUATION TO THE COMMUNICATION ZONE AND TO THE
ZONE OF INTERIOR.

The short period of time I performed duty in this country during the last war was entirely inadequate to make an appraisal of this subject. The Naval Hospital at San Diego no doubt carried a far greater burden of responsibility than was necessary. The large number of patients concentrated in one institution created a burden of considerable magnitude for all departments and it is believed that had those patients been more evenly distributed to hospitals in the central areas, much congestion would have been relieved and more beds would have been made available for incoming casualties.

Much thought and consideration has been given the subject of establishing hospitals for one type of cases, and to a certain extent this idea was carried out as related to the care and treatment of battle fatigue cases and convalescent institutions for the war wounded. I believe that this subject should be reopened and given much consideration, because it is entirely feasible to staff hospitals with specially trained medical personnel, and no doubt more successfully treat and rehabilitate such type cases." *****


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

**D-1j GENERAL RELATIONSHIPS WITH OTHER BRANCHES OF THE ARMED SERVICES
RELATIVE TO MEDICAL PLANNING AND REQUIREMENTS**

I. GENERAL

Because of the broadness of its scope, this subject requires consideration of organization of the Army and Navy during the last war from top to bottom as it affected the operation of their medical services. Further, it is logical that the study should point out specifically what organizational measures are indicated to prevent the recurrence of the same errors that were made and the wastage of resources that thereby occurred.

The evidence available for consideration has brought forth more definite comment concerning the basic need for a more adequate organization for the control of the entire medical effort in war than in any other subject considered. This is natural as the failures as well as the trials and tribulations of medical personnel in trying to do their jobs as they saw them during World War II stemmed in most part from the apparent general lack of importance given the medical service effort in all echelons of command.

The Medical Departments of the Armed Forces have today a directive from the Secretary of Defense to develop practical methods for the most economical use of all service medical personnel and facilities, especially in peacetime activities. This Subcommittee has assumed its mission to extend this directive to cover emergency situations of war. There can be no worthwhile results emanate from the current study unless all deliberations and recommendations are based on the sound premise that the medical service is only one of the many technical and supply services that are necessarily a part of our war-making machine. There can be no independence of any service in the fighting team. Each service depends upon all others for its operation and existence. All are necessary to gain success. Because of this each service is confronted with many identical problems in staff relationships. Each must restrain its natural desires to be considered pre-eminently the most important. The very fact of mutual dependence should be enough to bring forth mutual technical and supply inter-service agreement that each of the services must be equally represented at the top and on each staff echelon. No implication is intended that all of the service functions in the armed forces do not need

RESTRICTED

RESTRICTED

coordinated control, especially in the logistics field. This control must be supervised by some staff action on each level which should be limited to coordination only. Full recourse to the Chief of Staff and Commander in objecting to limiting staff decisions must always be possible. It should never have to occur in properly selected staffs. The use of liaison officers to effect staff coordination is sound. However, practice has demonstrated that medical representatives when so used should retain their status as members of the staff of the surgeon in every case and not be assigned to general staff sections where they soon lose their identity and develop a critical control attitude of things medical. Caution is necessary in submitting recommendations that would imply special consideration for the Medical Departments without adding the definite implication at least that all other comparable services receive identical recognition. It might be summed up by saying that the attitude should be "what is good for one is good for all".

There seems to have been lost in the cobwebs of time the lessons of history wherein the lack of a proper medical service lost wars. It can happen in the future and will if the Medical Departments do not from time to time retrieve these lessons for the consideration of the nation, its armed force commanders and the civilian medical profession as well. These days of uncertain national wavering are most appropriate ones in which to concentrate our Medical Department efforts in preparing our requirements of the future. To disregard the opportunity is to gamble with fate and worst of all, to fail in our responsibilities to ourselves and to our American people.

The armed forces have always been organized and operated from their beginnings without deviation from the fundamental that absolute authority and responsibility has to be and is vested in the Commander regardless of his echelon in the military hierarchy. Medical Departments in all their history have never questioned the soundness of that basic principle and should not at this time intimate in any way in action that because of the special conditions facing them at this time for united effort that a supreme medical commander for all things medical in the armed services is justified. It is a certainty even if the future brings true unification of the armed forces the chief medical authority will still exist only as a staff officer to the supreme commander.

Failures in application and serious wastages of medical resources occurred in World War II in the Army within each of the service medical departments because of faulty, unsound organization

~~22~~
RESTRICTED

RESTRICTED

which was directed by the War Department. This must never happen again and action is indicated to correct it.

Terms of the current law under which the three armed forces operate demand that Medical Departments of the Army and Navy maintain separate identity. It is pertinent to point out that the Medical Departments of the Army and Navy are only one of the many services which overlap in function under the current national defense establishment and it is only reasonable to foresee the time when each of the other services will be called upon to follow the Medical Departments in studies to effect coordinated effort. Methods by which more than the best possible coordination between the Army and Navy can be effected in all medical fields and which require the amendment of current laws or new legislation for accomplishment are not considered pertinent to the present study. The Command decision now in effect by which the Medical Service for the Air Force continues for the time being to be furnished by the Army has been accepted as a basis for procedure in this study. It is generally admitted as a failure that little and certainly insufficient coordination in the medical fields occurred between the Army and Navy during World War II except on the lower levels when joint Army and Navy medical staffs were operative. This fact that fine coordinated effort was possible and occurred in lower echelons in joint operations indicates clearly the absolute need for some form of a joint medical Army, Navy and Air Force body to operate in this field on the highest echelon attainable under the laws. This level is the Joint Staff of the Joint Chiefs of Staff. There is no question but that this joint body must be permanent in nature both in peace and war and that it must be established as a separate section of the joint staffs. There is some divergence of opinion as to the size and composition of this section. Some insist that the Surgeon Generals of the Army and Navy and the Air Surgeon must in being constitute the section. A sounder military organization which sets up a subsidiary staff consisting of senior, qualified representatives of the Surgeon Generals concerned with sole, full time duty in the section is favored as more practical to effect its purpose and mission. The scope of the mission of this section should encompass every area and aspect of medical activities in the armed forces. Essentially, it should be a strategical planning body whose main mission is to insure essential medical representation on the highest level of planning. This will fill the total void of World War II in which no agency was established to coordinate the efforts of the medical services of the armed forces. Its duties should be expanded to devise as the result of service investigations and studies of suitable methods for the improvement in all medical fields, and procedure to enable each of the Medical Departments of the Armed Forces to carry out in full its specific mission in peace and war with the strictest economy of medical resources of all nature.

RESTRICTED

RESTRICTED

The membership of this section must be thoroughly indoctrinated with the obvious fact that each of the armed forces medical sections has a particular specialty in its field which during war and oftentimes in peace is the most important factor in rendering its particular type of service. In furtherance thereof in all of its planning it must insure that adequate provisions are made to support these specialized service requirements. The fact that the section as planned would be composed of Army, Navy and Air Force personnel insures the equitable and desirable recognition for the different problems of each of the medical services as well as their protection from biased decisions. Only by this concept can the best possible use of all medical military resources be achieved. It is most unsound to proceed further on the insecure basis as has been past practice that the attainment of the most economical and well coordinated medical effort can be achieved through the casual meeting of extremely busy individuals who have other full time positions. This in itself can be conceivably cited as a waste of medical effort.

Suggestion has been made that the Medical Departments maintain closer liaison with the Information and Education Division of the Army at all echelons because of the importance of proper indoctrination in maintaining mental health of the individual. Experience overwhelmingly indicates the value of proper indoctrination of all who play a part in war, especially the fighting man. The Committee agrees that special effort in this field is needed to correct those failures in World War II.

Various sources have criticized the part the dental staff officer played in World War II. Some advocate that the Chief Dental Officer in every echelon be given staff autonomy separate from the Surgeon. While not denying that some instances did occur in this field which retarded the dental effort it is believed that most of the trouble arose from personalities and lack of confidence and leadership rather than the staff position traditionally given dental officers. To set up separate staff sections for each of the specialties of medicine is unthinkable and indicates no change in the position of Dental Surgeons.

II. ELEMENTS OF THE PROBLEM

1. World War II Medical Organization
 - (a) Joint Chiefs of Staff level.

RESTRICTED

RESTRICTED

No provision was made during World War II at this level to include medical support planning and direction for mobilization or for any of the military operations that later ensued. This lack of information as to what was contemplated resulted in delay, waste, error, inefficiency and efforts of each of the medical services to protect its own interest. This subject is fully discussed in the preceding pages of this report. A solution is offered to prevent recurrence of this glaring deficiency.

(b) War Department Level (World War II)

The Medical Department of the Army was relegated by an organizational directive which came without warning and which specifically prevented objection to a section of a newly created super colossus termed the Army Service Forces. The Surgeon General of the Army by this edict became in fact the Surgeon General only of the Army Service Forces and as such was unable to supervise or control the medical services of the ground forces and the Air Force components of the Army for which he was charged with responsibility by law. The volume of evidence that proved this system of organization was unworkable and totally unsound is sufficient to demand that never again should the medical-military profession be hamstrung so completely in the discharge of its legal responsibilities. The defense of that system that in the end the Medical Service of the Army was performed superiorly during the war under its auspices, does not justify the means used nor does it portray the constant friction, the many serious mistakes made, and the many actions that were necessarily taken by the Surgeon General in appeal to higher authority of ill-designed decisions of this agency. In the field of mobilization of its allotted medical personnel resources the Surgeon Generals of the Armed Forces must have complete autonomy to implement their plans if wastage is to be controlled. Staff coordination of effort is essential and should be accomplished on the basis of recognized competency of the involved service forces. Even when incompetence is patent, the control and cure for it does not rest in close supervision, debate, questioning and disagreement over the requests of the involved services. When singled out by the laws of the nation with sole responsibility for specific duties it is inconceivable that any service chief such as the Surgeon General should be hampered in the discharge of that responsibility by strings of attachment to any other agency which has the authority to make decisions adversely affecting the plans of his service. Either new legislation to place the responsibility elsewhere is indicated or cognizance of the provisions of the present laws in regard to medical responsibility should be demanded on the highest military level.

RESTRICTED

RESTRICTED

(c) Navy Department Level

The organization of the Navy on this level provided the necessary features to insure its Surgeon General and the Bureau of Medicine full control over its facilities to accept its wartime mission. The lack of criticism of its structure is mute testimony that it was soundly conceived. There is much criticism, however, in the lack of liaison permitted by the Bureau of Medicine with the Naval War Plans Section of the Naval Staff. This appeared to be solely due to the refusal of the Chief of the War Plans Section to have a medical officer on his staff. As a result serious mistakes were made which affected the efficiency of the medical service in all lower echelons. That this serious error can and should be corrected by proper command directive in the future is imperative.

There has been forceful representation made for the establishment of a staff medical section in the U. S. Marine Corps Headquarters. This is needed to develop and represent the medical needs for war in the operation of the Marine Corps. It is also recommended that a Department of Amphibious Medicine be set up in the Bureau of Medicine. Both of these suggestions have a sound basis and the Subcommittee feels that action in these areas is imperative as a means to overcome the difficulties encountered in the past war.

(d) The Army Ground Forces

This Agency was created during the mobilization phase of World War II. Its staff was patterned after the wartime general staff organization. It included a Medical Section whose Chief was designated as the Army Ground Force Surgeon. This Agency was designed to permit centralized and specialized control over the organization, mobilization and training of the Army Field Forces for use in the war. No special provisions were made for the carrying out of the overall responsibility of the Surgeon General of the Army in this force, it being assumed that the Surgeon of the Ground Forces would effect the necessary liaison with the Surgeon General of the Army to prosecute the necessary medical requirements. To the everlasting credit of the medical personnel of the staff of the Army Ground Forces it may be said that they cooperated in a superior manner with the Staff of the Surgeon General's Office in promoting effective results in the medical field even though it

RESTRICTED

RESTRICTED

could have been correctly decided that the Surgeon General had by faulty reorganization of the Army been relegated to the same level as theirs in the Army Service Forces. The minor clashes of opinion that arose were inconsequential and are not worthy of comment.

(e) Service Command and Naval District Level

Severe criticism has been elicited of the method by which the large medical training facilities of the Medical Department of the Army were operated under service command control. These facilities were at various times under the direct control of the War Department and at others under service commands. It is agreed by Medical Department officers concerned that they operated smoothly and efficiently only when under direct War Department control. When placed under service commands every conceivable difficulty arose. The most important of these were the diversion of authorized trainer and administrative personnel to other service command functions and the interference in training by incompetent non-medical staff agents. The Commanding Generals of these training centers found themselves without the means to acquit their responsibilities in every case. It was argued that the Surgeon of the Service Command should have represented the medical training centers at Service Command Headquarters. That this did not work has been amply demonstrated. All favor the direct control by the Surgeon General in the future of all large medical training facilities to avoid the serious infringements of authority and the constant wrangling that occurred in past practice when they were placed under area commanders who proved themselves unable to supervise medical training in any field.

There was little criticism elicited in the field of staff or command interference with the Medical Department of the Navy installations within the Naval Districts of the United States. It is believed that much less interference occurred and no constructive criticism can be offered to better the organization in the future.

(f) Theater of Operations Level

Serious difficulties arose in the Army in several Theaters of Operation because of the practice of relegating the Chief Surgeon to the S.O.S. after the pattern of the War Department in the Zone of Interior. There was much restriction thereby placed on his supervision of Ground and Air Force medical activities. It was partially overcome in some instances by personal acquaintanceship

RESTRICTED

RESTRICTED

factors. This brings out forcibly the fact that any plan or organization which depends for success solely on personalities is unsound and needs correction. The medical sections on any level must be separate entities on the highest staff in the future if we are to discharge our responsibilities in full. The morale factor and hence efficiency in the lower medical echelons is directly affected by the position that the medical section occupies with respect to authority on the highest level.

The evidence reveals that the cooperation in planning and in joint utilization of medical facilities in the various theaters was exceptionally good. The relationships were cordial and mutually effective in producing desirable results.

On the Navy side there is nothing quite comparable to the organization of the Army for a Theater of Operations in the Medical Field. Naval medical facilities afloat and ashore were controlled in acceptable fashion from all reports except that severe criticism is given in the priority of construction of medical installations ashore in several instances. The facts show that ice cream factories and officers clubs were constructed in some areas prior to the hospital facilities, which had to function in the tropical mud for long periods because of this practice. It was similar to the experience in the Army that hospital construction did not receive the priority or importance it demanded.

Evidence shows that it was not until late in the war that Navy line commanders in the large fleets accepted medical staff officers and it appears that often severe hostility was encountered even then. Medical planning at the high level suffered from this practice and as a result most of the serious medical errors occurred in amphibious operations. There can be no question as to the necessity for changing this attitude, in the future if the same errors are to be prevented. Discussion of the need of further indoctrination of line Navy officers in all medical fields is contained in another section of this report.

Late in the war combined Army and Navy staffs afloat on the highest level produced excellent results. This demonstrates the necessity for close coordination and cooperation in joint operations. It must be made the practice early in the future.

RESTRICTED

RESTRICTED

(g) Field Army and Task Force Level

Nothing but the highest praise can be given to the operation of the medical service on the field army level during the war. The Army Surgeons were unhampered in the discharge of their duties from beginning to end. This resulted from the confidence placed in them by commanders and staffs with whom most of the surgeons had been trained in Army Service Schools.

On the Navy side it was not until late in the war that surgeons were accepted by task force commanders. The record is replete with recriminations of the attitude and actions of the commanders and staffs for their hostility to the medical representation. The withholding of information as to plans and the overriding and disregard of medical requirements by task force commanders forms an ignoble page in the history of naval operations in the Pacific. The corrective action is plain. Sufficient training of Naval line and Naval medical officers in Medical Department matters is imperative if they are mutually to acquit their responsibilities more fully in the future.

III. CONCLUSIONS

The Committee concludes:

1. That the organization of the War Department in World War II was seriously faulty in that it relegated the Surgeon General of the Army to an inferior level in the Army Service Forces which prevented him as the head of the Medical Department of the Army from discharging his legal responsibilities in full.

That this mistake should never be made again.

That action to lay the groundwork for its prevention in the future is indicated now.

2. That little or no coordination between the Medical Departments of the Armed Forces occurred on the highest level during World War II.

That under the terms of current laws the Medical Departments of the Navy and Army must remain separate.

That because of this the fullest cooperation and coordination of their efforts must be accomplished continually in peace and in war.

RESTRICTED

RESTRICTED

That because of the uncertainty of the future and final status of the medical service of the Air Force, it is necessary to include for the time being representation of the Air Surgeon in joint medical matters. That under the law this can only effectively be accomplished by joint Army, Navy and Air Force medical representation on every level in which the problem needs action.

That at the top level this can best be accomplished by the creation of a joint medical section in the Office of the Joint Staff of the Joint Chiefs of Staff.

That the need for action to accomplish this is imperative at the moment.

That the present Joint Committee on Medical and Hospital Services of the Armed Forces now sitting on the Secretary of Defense level should continue in being until some permanent arrangement for its functions is established.

3. That insufficient importance was given in the Navy Department to its medical effort in planning and in execution of its amphibious operations. That actual hostility of naval commanders to medical representation on their staffs exhibited a gross defect in the Navy system.

That to prevent the serious errors of World War II in the future, aggressive action by the Surgeon General of the Navy to stimulate the necessary corrective measures is imperative during these peace years.

4. That coordination between the medical services of the Army, Navy and Air Force in Theaters of Operation, especially in the final days in the Pacific was most noteworthy and deserving of emulation in the future.

5. That control of all training activities of the Medical Departments in times of war by the Surgeon Generals concerned is sound and essential to produce the best results.

That adoption by the Army for its Medical activities of Navy methods as presented by Navy General Order 245 for control and operation of medical facilities in the Zone of Interior is indicated at once.

RESTRICTED

RESTRICTED

That such action will prevent the interference experienced during the war from Service Commands.

6. That in some Theaters of Operation relegation of the Chief Surgeon and his medical section to the staff of the S.O.S. hampered the medical effort and is unsound.

That to correct this deficiency action must be taken during peace to establish proper organizational systems in the Army which will place the Chief Surgeon in his proper place on Theater of Operations staffs.

That this action must originate and be pressed by the Surgeon General of the Army of the errors of World War II in this field are to be prevented in the future.

7. That if the Marine Corps medical service is to be improved over World War II standards which were not too good, it is imperative that a medical section be created for the headquarters of that force.

That to effect the best development of amphibious medical service that a section for that branch is essential in the Bureau of Medicine of the Navy.

IV. RECOMMENDATIONS

The Committee recommends:

1. That action be taken at once to create a joint Army, Navy, Air Force medical section in the Joint Staff of the Joint Chiefs of Staff level.
2. That the present Committee on Medical and Hospital Services at Secretary of Defense level be continued until the action in (1) above is consummated.
3. That action be taken by the Surgeon Generals of the Armed Forces by proper staff methods to:
 - a. Assure their position in wars of the future on the proper staff level.

RESTRICTED

RESTRICTED

- b. Assure the position of Chief Surgeons in Theater of Operations on the Proper staff level.
 - c. Press the adoption by the Army and Air Forces of the Navy system of supervision and control for their respective medical installations as prescribed in Navy General Order 245.
4. That action be taken by the Surgeon General of the Navy by proper staff methods to:
- a. Assure the proper indoctrination of the Navy Command on all levels on the importance of the medical effort and the necessity for the use of medical staff representation on all levels, especially in forces coordinating amphibious warfare.
 - b. Assure the creation of an amphibious medical section in the Bureau of Medicine of the Navy.
 - c. Assure the establishment of a medical section in the headquarters U.S. Marine Corps.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Brig. General Roy C. Heflebover, USA (Ret.)
dated (undated) - received 30 April 1948)

"3. My experience during the late war was confined to three and one-half years in command of the Medical Training Center at Camp Barkley, Texas, which also included a Medical Administrative Corps Officer Candidate School; and approximately one year in command of the Hospital Center at Camp Butner, North Carolina. Consequently, my experience does not justify comment on many of the questions referred to in your letter. Further, the necessity of making an immediate reply does not permit the time necessary for full consideration of all the matters which fall within the scope of my experience. However, comment is made on those deficiencies or difficulties which in my opinion are outstanding.

In both the installations commanded by me I feel that the greatest difficulty encountered was due to the fact that these purely technical installations were made a part of the Service Commands and did not function directly under the Surgeon General.

4. The training center at Camp Barkley was activated on October 29, 1941 and, at the time, was a part of the Eighth Corps Area (later the Eighth Service Command). In December, 1941 the Center was removed from the Corps Area control and given the status of an exempted station. A year later it was placed back under the Eighth Service Command except for the promulgation of the training doctrine, the training program and the selection and assignment of personnel. Four months later, in April, 1942, the personnel was put under the Eighth Service Command, and one month later the supervision of training, but not the training doctrine and training program, was released by the War Department to the Eighth Service Command. Thus, there was ample opportunity to observe the advantages and disadvantages of both systems, one while under the direct control of the War Department and the other while under the direct control of the Service Command. This experience proved conclusively that functioning directly under the War Department made operations far less difficult than when the installation was under the control of the Service Command.

5. The training program was prepared by the Surgeon General under the supervision of the Training Division of the Army Service Forces, and when operating directly under the control of the War Department interpretations of this program and of other basic directives were made by the commanding general of the Center who was a medical officer. On the other hand, when under the Service Command, interpretations were frequently made by officers in the Training Division at Service Command Headquarters who

RESTRICTED

(j)

RESTRICTED

were line officers and not versed in Medical Department tactics and technique. As one outstanding example of the latter may be mentioned a criticism of the training at the Center at Camp Barkley by an inspector from the Training Division at Service Command Headquarters. In an official report he criticised the training as being deficient in regard to the proper conduct of advance and rear guards, special emphasis being laid on the fact that flank patrols were not posted. This is conclusive evidence that the inspector was entirely uninformed as to the Medical Department training program. Rear and advance guard tactics belong to the combat arms and are not executed by unarmed Medical Department organizations. In order to protect columns marching along the road from motor vehicles, it was required that all such columns provide for a small party to march in advance and another to march in the rear of the column to be on the lookout for and to warn against approaching motor vehicles. It was this that the inspector in question criticised as faulty advance and rear guard action.

6. In a Training Center there is nothing of more vital importance than the sufficiency and quality of the officers and men who constitute the permanent cadre and are responsible for the training. While under direct control of the War Department there was provided an allotment of officers and men by grades which was ample in numbers to properly perform its function, and it was possible to maintain the desired quality of the personnel. In April, 1943 when control of personnel in the Center was transferred to the Service Command, the War Department increased the allotment of personnel to the Service Command by the numbers and grades which it had previously allotted the Training Center. Generally, the Service Command maintained allotments similar in numbers and grades, but extreme difficulty was experienced in promoting men of the Command to the grades provided by the allotment authorized by the Service Command, and it was never possible to get all of the personnel provided by the allotment. The status of allotments and existing strength of officers and men at one period in the history of the Center is shown below.

COMMISSIONED OFFICERS

	Allotment of 2 June 1944	Actual Strength 30 June, 1944
Colonels	8	3
Lieut. Cols.	29	11
Majors	54	28
Captains	200	134
1st Lts.	222	163
2nd Lts.	<u>227</u>	<u>253</u>
	740	602

RESTRICTED

RESTRICTED

ENLISTED MEN

<u>Grades</u>	<u>Allotment of</u> <u>3 June, 1944</u>	<u>Actual Strength</u> <u>30 June, 1944</u>
1st	101	89
2nd	33	30
3rd	160	131
4th	715	543
5th	1,254	872
6th	432	352
7th	399	680
	<hr/>	<hr/>
	3,094	2,667

7. The result of the foregoing was conducive of extremely poor morale both among commissioned and enlisted personnel of the cadre. The allotment made provisions for colonels to command regiments lieutenant colonels to command battalions, etc., but it was necessary to have lieutenant colonels command regiments and majors command battalions, and in some cases lieutenants to command companies. Recommendations for the promotion of officers fully qualified, in spite of the fact that there were ample vacancies in those grades. The same was true of enlisted men, and frequently an excellent sergeant (4th Grade) was the 1st sergeant of the company while the same position in other companies was held by enlisted men of the 1st grade. Thus, it can be seen that although the War Department had carefully prepared allotments for training centers and added these allotments to the strength of the Service Command when the latter was given control of those centers, the centers themselves did not receive what the War Department considered necessary for their operation but the higher ranks and grades went to other places within the Service Command. If, in future emergencies, training centers are placed under the jurisdiction of Service Commands, it is believed that efficiency demands that the War Department provide a table of organization or an allotment of permanent personnel by numbers and grades and require that the Service Command adhere to it. *****

11. My experience at the Hospital Center at Camp Butner, North Carolina, in regard to difficulties incident to operation under the Service Command were in general similar to those at Camp Barkley. In the beginning the Hospital Center was ordered to "operate as an integral activity of the 1460th Service Command unit personnel assigned to all activities" at Camp Butner. The commanding officer at Camp Butner was to provide all technical and supply services other than Medical Department for the Center. The commanding officer of the Center was to be responsible to the Service Command "for all matters pertaining to the

RESTRICTED

RESTRICTED

14. The foregoing would seem to again conclusively prove that with responsibility there should go the requisite authority and the means for the carrying out of the assigned function.

15. The argument in regard to the control of technical installations is an old one. My own experience during the past war in commanding the largest training installation of the Medical Department, and in commanding of one of the largest hospital centers confirms me in the belief that Medical Department installations of this type will operate more efficiently and more economically in all respects under the direct control of the War Department, and thus in effect under the Surgeon General. To interpose between the War Department and these installations a Command whose heads are not technically trained makes for greater difficulties in operation and in my opinion for less efficiency. It may be argued that the Commander of the Service Command has on his Staff a Medical officer who can advise and assist him in the operation of Medical Department establishments. In my own experience at Camp Barkley during the more than two years that the Center functioned under the Service Command, the Service Command Surgeon never made an inspection of the Center nor did more than on one or two occasions pay a brief visit to my office. Thus, he was certainly not fully familiar with the problems existing at the Center and not qualified to give proper advice if it were sought. "*****"

RESTRICTED

L. K. Pehl

L. K. Pehl, Colonel, MC

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E. R. HERRING, JR., (MC) USN on 22 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** J. "The other major deficiency, I believe, was in the lack of a centralized doctrine which emanated from higher authority which might serve to back up our medical officers on those staffs, and give more authority to their desires regarding planning. By that I mean, we might wish to have certain medical facilities available, but many times our desires were overridden by rather unempathetic task force commanders.

One glaring deficiency is our absolute failure in the matter of preventive medicine -- and it is a basic error that has not been corrected -- and that is with the actual fighting troops themselves. Now I refer to the Marine Corps, who have very few service elements. They realize their efficiency, but the fighting man cannot do sanitation as he fights. And while the establishment of malarial control units was a fine step in that it told us what our problem was, we had no personnel to carry out the recommendations. It was attempted, in various ways, to take care of this matter.

Eventually the OB's were increased, and we were supposed to get these men for training and for actual operation in the field. However, their primary function is road building, airport construction, and so on, and that primary mission overshadowed their sanitary employment and preventive medicine employment; and we just didn't have the preventive medicine that approached the problem whatsoever. We got every disease that came along.

Further than that, I would like to show you a document from the Chief of Naval Operations to the Commander in Chief of the Atlantic Fleet regarding the offshore evacuation casualties. I was allowed to comment on this plan, and my comments were as strong as I could make them. They were completely disregarded.

The necessity for Medical Representation at Joint Chief of Staff level as Permanent Advisers to the Secretary of Defense. That, in my opinion, is such a necessity that it is almost obvious. We have just got to have it.

Provision of a Constant and Firm Policy Directed by the Secretary of Defense to Insure Direct Command Level Medical Staff Representation throughout all Echelons of the Armed Forces. At a level like that, I could only say that the necessity to me is just obvious. It has got to be there. We in the field would have our morale go up 1,000 percent if we knew that we were represented.

A National Registry of all Physicians as licensed by State or Territory for the Practice of Medicine and Surgery. Along that line, as it affects me in my employment in the service right now on the job I have, this Registry would certainly serve a great purpose.

General relationships with other branches of the Armed Services relative to medical planning and requirement. The very name joint operations refers to amphibious forces, which is a joint operation between the land and sea forces. Our medical planning must be coordinated with that of the army.

I can give you example after example of that, but it would just be repetitions where it wasn't carried out. And, that is my argument for this joint board on amphibious matters.

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT E.R. HEMING, JR (MC) USN ON 22 APRIL 1948.
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES CONT.

In my arguments in regard to a strong department of amphibious medicine, which should be a joint representative board, it would have the following functions: it would serve as a central agency for reception of new developments of amphibious techniques and would be the promulgator of such developments as a uniform doctrine.

A lot of this overlaps, as you understand. Right now the doctrine is going back instead of going forward. Maybe my feeling is wrong, but I feel that I am all alone in this branch. I can see no improvement; I can see nobody else going forward on it. If it isn't going forward, then I just feel that I am wasting my time.

This joint board will advise on the overall planning of the medical requirements for any contemplated operation, the strategical planning. The tactical planning should be left to the actual personnel who are going to execute the operation, but the strategical picture should be left in the hands of a joint board.

I feel that this board should certainly supervise the training program. First they have to set one up, then supervise it. And they should certainly have some say as far as the assignment of personnel to amphibious forces, so that we will be assured that at least some trained personnel will be there to execute whatever plans are made. This board should, further, maintain careful cognizance of the state of readiness of the amphibious units.

I have covered that before, in the matter of inspections of both the forces afloat and my particular unit.

This board should be at a level which would allow it to have a part in the overall planning and it should also be at a level where it could keep its feet on the ground and maintain contact with the tactical forces.

I feel that all the detailed work that needs to be done in the field of this kind, in the planning and preparations, that it possibly would overburden one medical officer at the Joint Chiefs of Staff level, and that in view of the fact that the responsibility for amphibious warfare development has been assigned to the Marine Corps and that the initial impact of casualties must be taken care of by the forces afloat, that this board should be at the bureau level, and preferably in the Bureau of Medicine and Surgery. However, it must have representation, or close liaison, with the Army and Air Forces for the reasons previously given. *****

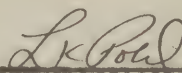
RESTRICTED
L.K. Ford
L.K. FORD, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Letter from Colonel Richard T. Arnest, Ret.
dated 19 April 1948)

***** " j. There should be no distinction between the Army, Navy and Air. All should be one. The administration records and forms utilized should be uniform for all branches and no distinction made between them. Much overall personnel could be saved in this manner. Medical planning must be coordinated by the surgeon of the major branch who has a final say in case of disagreement on any set plan or requirement." *****



L. K. Pohl
Colonel, U. S. Army

TRUE COPY EXTRACT (Ltr Capt. R.R. Hering (MC) USM dtd 17 Dec 47)

***** J. "Lack of Medical Staff in Marine Corps Headquarters. Many directives had a definite bearing on the Medical Corps indicated clearly the lack of consultation with a medical officer trained in amphibious medicine. This was especially true of logistic directives. I can recall quite clearly that while a directive from MarCorps called upon the 5th Corps to rehabilitate one division plus a reenforced regiment following the Tarawa engagement, not one unit of field medical equipment was available in the Naval Medical Supply Depot in the Hawaiian Islands. A further example in peace time will suffice to show the need for such a medical staff. In February 1946 Marine Corps Headquarters was ordered by GHO to form a Brigade and have it ready to embark for a trouble zone in fourteen days. Not until eight days later was I ordered to Marine Corps Headquarters to organize the Medical support and on reporting over to the Bureau, I found that not one step had been taken to either order personnel or supplies, in fact, nobody had heard of the proposed organization. In an effort to correct the above deficiencies and to bring the Amphibious and Field Medical Service to a position where it can rapidly expand into a well organized, trained and equipped department in time of war, the following recommendations are made: a. Establishment of a Department of Amphibious Medicine in the Bureau of Medicine and Surgery on equal parity with Flight and Submarine Medicine. This department would be responsible for making recommendations as to the assignment of personnel to Amphibious and Marine Corps Forces the coordination of development of equipment and doctrine and serve as a clearing house for ideas and recommendations coming from forces in the field. b. Establishment of a Medical Staff in Marine Corps Headquarters. This staff would be responsible for advising the Commandant on matters bearing on the medical department with the Marines in the field. It would keep the Bureau

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Ltr Capt E.R. Hering (MC) USN, dated 17 Dec 47) CONTINUED:

informed of any contemplated change in policy or organization in the Marine Corps. It would keep the Material Division advised on logistic matters and overall supply requirements. It would further be responsible for inspection of the medical forces in the field in conjunction with the ADI Department in Marine Corps Headquarters.*****

REC *L.K. POHL* ER

L.K. POHL, Colonel, MC

TRUE COPY EXTRACT (Ltr Capt M.S. Mathis (MC) USN, Dtd 6 May 48)

***** J. "Coordination in planning for procurement of supplies and equipment is essential if there is to be equitable distribution. Coordination in planning for distribution of supplies proved to be practicable between Army and Navy Medical Supply Depots in Pearl Harbor. Coordination in planning proved to be practicable between Corvallis Naval Hospital and Camp Adair in Oregon. Camp Adair deactivated when the Navy took over the hospital. Later it was reactivated to between 20,000 and 25,000 troops and again deactivated just prior to decommissioning of the hospital. Many of the utilities such as coal docks, water supply and purification, sewage, cold storage and electrification were under control of the Army with certain portions assigned to the hospital for administration. Relationship was cordial and no difficulties were encountered.*****

L.K. POHL

L.K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr Alfred W. Eyer, Captain (MC), USN, 17 April 1948)

****(j) General relationships with other branches of the Armed Services relative to medical planning and requirement.

Medical planning and procurement of requirements of the Armed Services should be as fully joint as practicable functioning will permit. This applies to the Bureau level. Joint Chiefs of Staff level and the Theater Commander level. It is anticipated that the mere knowledge of "what the other fellow is proposing to do" will do much toward eliminating reduplication of effort and confusion.

Further, planning on the Bureau level should encompass joint utilization of civilian facilities potential in possible emergency situations. " ****

L. K. Pohl
READER

L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee, dated 18 April 1948)

***** (j) General relationships with other branches of the Armed Services relative to medical planning and requirement.

"In the medical service there is the most urgent need for a truly unified service. There are no essential differences between the problems in the three branches. Allegations that service on a ship, or with a squadron of aviators, is a special thing is largely bosh inspired by desire to preserve 'empires'. There should be one system of hospitals, one supply table, one uniform, one set of physical standards, in short, one medical service." ****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr Col Harry G. Armstrong, MC, 16 April 1948)

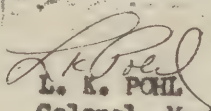
**** "j. General Relationships with other Branches of the Armed Services
Relative to Medical Planning and Requirement.

(1) Defects:

- (a) Inadequate staff planning.
- (b) Jealousy between branches.

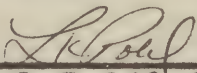
(2) Remedies:

- (a) Medical officers better trained in staff duties.
- (b) Unbiased civilian boards to establish medical requirements for the various services." ****


L. K. POHL
Colonel, M. C.

TRUE COPY EXTRACT (Letter, Captain J. H. Robbins, (MC) USN
dated 26 April 1948)

***** "All Force and Area Medical Officers should be assigned to duties on the Staff directly under the Force or Area Commander and not as a sub-department under one of the sections. This is of vital importance when planning new campaigns., as the Force Medical Officer should be placed on the highest echelon level in order that he can plan and coordinate all medical departments." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr W. H. Michael, Rear Admiral (MC), USN, Retired)

**** "In the hostile atmosphere in which I found myself in the Seventh Fleet, I was not asked to be present at operational staff meetings and had some difficulty planning logistics. This defect was in most part corrected by information I obtained from the Army Medical Department."

L. E. Pohl
RECORDED
L. E. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Colonel John A. Rogers, MC, USA (Ret.)
dated 19 April 1946)

***** "J. General relationships with other branches of the Armed Services relative to Medical Planning and Requirement. The placing of the Surgeon General of the Army on the staff of the Commander of the Service of Supply was a very serious handicap. This also occurred in the European Theater. During the training and concentration period in England and the planning period prior to D-day, the Theater Surgeon was on the staff of a subordinate commander. This made for uncertainty in relationships which was overcome by mutual cooperation but not through command channels. The same applied on the Continent where the Theater Surgeon was on the staff of the Commander of the Communication Zone. That it worked was due to mutual acquaintanship and appreciation of needs. It is believed to be faulty organization. This statement is made with full knowledge of the fact that it is the desire of the commander to be relieved of administrative details." *****

L. E. Pohl
RECORDED

L. E. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 22 April 1948)

***** "(j) Certainly in the case of the army the Surgeon General ought to be at a place where he can assume his full responsibility for the health of the army. He can't do this as the Chief of an Army Service Force and therefore have no direct authority over the Ground Force or the Air Force. If we are going to have a Surgeon General of the army then he has to be in a position to exercise his authority. Even many of the other arms of the service in the Army Service Forces was commanded by a three star general whereas the medical forces never had but a two star general. To those of us in the field of medicine this seemed grossly out of line. My impression is that it is still true. On what basis should the Inspector General have three stars and the Chief of all medical and health services of the army have only two? *****

***** Apparently there was considerable autonomy in the interpretation of regulations which may always have to be the case. In this instance I refer specifically to the refusal of certain large areas of command to accept recommendations for a section 8 discharge. At one time one of the Service Commands decided that it would review every case of discharge for psychiatric reasons with the result that one particular camp built up a backlog of 4500 men who should have been discharged. Some person at high levels ought to be able to stop such nonsense.*****

TRUE COPY EXTRACT (Letter from Dr. Wm. C. Menninger, Topeka, Kansas, dated
29 March 1948)

***** "(10) A much closer liaison ought to be established between the medical department and the I and E Division on the basis that motivation is an extremely important factor with regard to mental health."*****

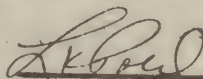

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Robert M. Gillett (MC) USN
dated 15 April 1948)

***** "Adequate medical representation of the other services on
staffs was not uniformly permitted during World War II. This led to
hard feelings and misunderstanding which should not have existed."



L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Captain Lewis T. Dorgan (MC) USN)

***** "(j) General relationships with other branches of the
Armed Services relative to Medical Planning and Requirements.

"This has been touched upon under other headings.

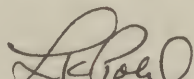
"Suggested Remedies:

"(1) All Medical logistics should be joint service with definite
responsibility designated to the Army for all "medical stores and
hospitalisation ashore, and to the Navy for those activities afloat.

"(2) Surface evacuation of wounded should be in fast ambulance
type ships under Navy Control.

"(3) Hospital ships of the present type could be dispensed with
entirely; if they are kept, all should be under Navy Control.

"(4) Air evacuation of wounded should be utilized whenever
possible. It should be an independent organization set-up and opera-
ted by the Air Force." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Emmett D. Hightower (MC), U. S. Navy
dated 21 April 1948)

***** "(j) Close liaison should be maintained between all branches of the armed forces relative to medical planning. This should begin with the highest echelons and should apply not only to planning for casualty care, combat landings and operations, but also to evacuation policy, rear area hospital facilities and all other medical service requirements."*****

***** Two major problems confront military medical services -- the first, treatment of wounded men and their return to duty -- the second, illness. Since seasoned and well-trained soldiers and sailors are of inestimably more value than raw recruits, and since manpower is always limited, it is imperative that the medical services shorten the healing process and return to duty of the wounded, and effect hygienic, preventive and epidemiologic measures to reduce casualties from disease.

"Medical services furnished must be based on the foregoing concepts -- treatment of casualties, and prevention of disease. Careful planning is the corner-stone but, in addition, there must be flexibility of mind in military commanders and elastic organizations to sanction methods which evolve increasingly rational and effective care of the wounded. The concentrated experience and the accelerated activity that accompany war, permit a more rapid evaluation of methods and procedures. Measures which prove ineffectual can be discarded, and those found efficacious just as quickly expanded.

"Medical Officers selected for the job of Fleet and Force Surgeons should be carefully chosen. Certainly they should be familiarized with the intricacies of staff work, either by special courses of instruction or by attendance at the Naval War College or other Staff Colleges prior to being assigned. They should be given more authority and latitude, particularly in the sphere of personnel assignment, in order to more effectively and expeditiously solve problems arising in their theater of war. In the last war many Medical Officers were assigned to staff jobs without much idea of the implications of the position and were hampered in the proper performance of their duties. They were indeed fortunate if the Admiral possessed a flexible mind and was sympathetic toward the problems confronting those concerned with the care of casualties, but such was not always the case. A staff Medical Officer, of necessity, must be energetic, tireless, and tactful; in addition, he must have access to all matters under consideration in the Plans and Operations Sections of the staff in order to write the Medical Annex of Operation Plans for attacks on the enemy.

"I believe that, in future emergencies, Inspectors of Medical Department Activities should be in constant touch with responsible medical department personnel in the forward areas. An inspection trip can be made and plans and policies formulated, but, however, the tactical situation can change overnight and obviate procedures already outlined. The Inspector should be attached to the Staff of the Area Commander in order to enable him to have the authority to expedite changes in plans and policies as the need for changes arises. For example, Advanced Base Hospitals could be shifted by his order, when the obvious need became apparent, without the necessity of obtaining Bureau approval." *****

614

RESTRICTED

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY (Extract Ltr M. C. Stayer, Major General, U. S. Army, Retired, 18 Apr 48)

***** (j) General relationships with other branches of the Armed Services relative to medical planning and requirement.

It is my firm belief that there should be close coordination between the Armed Services in medical planning and requirements. In the recent World War, there was very little, if any, coordinated planning by the Armed Services, at least in the Theatre in which I happened to be. This caused great duplication in construction, personnel and material.*****

RECORDED

L. K. POHL
Colonel, MC

TRUE EXTRACT COPY (Ltr Brig.Gen. Wm B. Dault, MC, Surgeon, dtd 13 Apr 48)

***** J. "It seems to me imperative that we take a lesson from the way the medical service of the country was organized in World War I. That lesson is vividly described in a book written by Dr. Franklin Martin. His position in the national defense program was of such a character that he was able to approach not only the Secretary of War but the President himself on vital matters affecting the medical service of the country and the Armed Forces. Therefore, our first approach should be to make certain that a Medical Section is established on the National Security Resources Board and that the head of this Medical Section be a man who is of such prominence in the medical world as to be known not only to the Security Board but to the President. Likewise there should be a Medical Section on the Joint Chiefs of Staff. If the Chief Medical Officer of the three armed services has not had broad experience and extensive education in medico-military administrative affairs, he should surround himself with those members of his services who have been educated in our war colleges, general staff schools and the like. A number of the faults of the medical service in the past resulted from the fact that the War Department did not have confidence in the communications and recommendations which reached it from the Medical Department. It is essential that the officers of the administrative and technical services be known to and have the confidence of the staffs of the higher echelons of command with which they deal. This is order that their recommendations may receive merited recognition without too much wrangling. Likewise it is essential that officers dealing with General Staff officers have educational advantages along General Staff lines comparable to the officers with whom they deal. "*****

RECORDED

RESTRICTED

L. K. POHL
Colonel, MC

615

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain E. D. Templeton, MC, USN
dated 23 April 1948)

**** "(J) GENERAL RELATIONSHIPS WITH OTHER BRANCHES OF THE ARMED
FORCES RELATIVE TO MEDICAL PLANNING AND REQUIREMENT.

On every occasion I found that the best relationships existed with other branches of the armed services. The spirit of cooperation and helpful assistance was most apparent and every requirement of the medical department was considered and complied with if at all possible. This cooperative relation existed on all ships that I served, and in every instance all officers and men assisted in conducting first aid and giving relief to battle casualties; they demonstrated a sincere respect for first aid practices and entered into all training exercises with much interest and enthusiasm.

It was quite noticeable as the war progressed that all branches of the armed services held the medical department personnel in high esteem, and on no occasion were medical supplies and personnel withheld if they were procurable.

All branches of the armed services were vitally interested in general sanitation procedures and malaria control. Preventive measures were brought to their attention in a forceful manner, and it was possible to carry such control measures through to a successful conclusion." ****

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

616

RESTRICTED


TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

**** "j. The general relationship with other Branches should be equal and well coordinated with the appointment of liaison officers where two or more Branches are operating jointly, regardless of rank, each Branch representative should have equal powers."

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus, (MC) USN
dated 27 April 1948)

***** "(j) It is essential that close liaison be maintained with other branches of the Armed Forces for planning purposes if proper over-all medical logistic support is to be provided. Medical Department representation with active participation should be an integral part of all planning offices and agencies, especially those in the higher echelons. You can not give the answers unless you know the score." *****

RESTRICTED



L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert K. Simpson, USA (Ret.)
dated 1 May 1948)

***** (j) General relationships with other branches of the Armed Services relative to medical planning and requirement. No comment other than I am of the opinion that there were too many echelons of command requiring a medical staff, and there were far too many medical officers on staff assignments. For example, in the Flying Training Command, Army Airforces, there were a surgeon and his assistants assigned. Under this command there were a surgeon and his assistants assigned. Under this command there were three training centers, each with a more than necessary staff. As a matter of fact, I see no necessity of having had such a staff of medical officers at all with the Training Centers. All Medical Department Administration could just as well been attended by the Surgeon's office, Flying Training Command. As surgeon of the Central Flying Training Command (the lower echelon) I was required to have an assistant, a Veterinarian, a Dental officer, a venereal Disease Control officer, etc., etc., when it appeared to me at least the whole organization was an unnecessary cog in the machine. As Surgeon of the Far East Air Forces I saw no necessity of there being a staff surgeon, with his assistants, for each of the two Air Forces (5th & 13th) the components of the Far East Air Forces. Hospital installations within the theatre of operations may be planned to serve all branches, and thus avoid reduplication of effort and energy. The same is true as regards evacuation. There should be an overall joint plan of the Army, Navy and Air Arm as regards hospitalization and evacuation for each campaign.*****

RECORDED

L. K. Pehl

L. K. Pehl, Colonel, MC

RESTRICTED

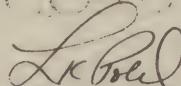
RESTRICTED

TRUE EXTRACT COPY (Letter from Capt. Warwick T. Brown, (MC), USN
dated 20 April 1948)

***** "j. General relationships with other branches of the
Armed Services relative to medical planning and requirement.

In my experience this was generally harmonious and
mutually satisfactory. *****

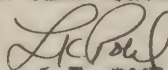
RECORDED



L. K. Pohl
Colonel, U. S. Army

TRUE EXTRACT COPY (Ltr Brig Gen Guy B. Denit, MC, Surgeon, 13 Apr 48)

***** J. "General relationships with other branches of the Armed Services
relative to medical planning and requirement - There must be a Medical
Section of the Joint Chiefs of Staff with someone over this Medical
Section that has the authority to make decisions and to resolve differences.
A committee of three chiefs that depends solely upon agreements is not
sufficient in time of strife. The resources of all the armed services must
be available to each of the armed services in such measure as may be re-
quired during wartime.*****



L. K. Pohl
Colonel, US Army

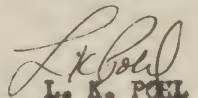
RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Albert T. Walker, Captain, MC, USN, 26 April 1948)

*****Any future war is going to be an "all hands" evolution" as far as the citizens of the country are concerned and for this reason, I feel that total mobilization of all medical facilities is essential. This could best be accomplished by a Joint Medical Staff composed of military and civilian medical leaders coordinated at Cabinet level. This will require the appointment of a U. S. Surgeon General to be a Cabinet member. This Joint Medical Staff should be formed and commence functioning for planning purposes at once. I realize this is a radical suggestion but feel that vigorous methods must be employed if we are to spread our medical care sufficiently to include not only the Armed Services but the civilian population as well.

With respect to general relationships of the other branches of the Armed Services relative to medical planning and requirement, my experience may have been unique, but certainly no greater cooperation could have been achieved than that between the medical services of the Army and Navy in the Southwest Pacific Area. Our supplies were interchangeable, the Navy assumed complete casualty care in every operation until such time as the Army units could be properly set up on the beach and after that had been accomplished, we then assumed complete care from the far beach to the Base Hospital. In two instances, Army and Navy hospitals combined to receive patients from either service, thus relieving valuable beds and facilities to be used elsewhere (Sydney and Brisbane, Australia). It is absolutely essential of course that complete cooperation between all the branches of the Armed Services be established and maintained." *****


L. K. POEL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Quinton M. Sanger, BUMED, USN 15 April 1948)

****"Various criticisms were made of "Line" - "Staff" relationships. It was maintained that no Line officer should be permitted to exercise authority over a medical officer with respect to the health or physical welfare of Navy personnel, regardless of general Navy precedents and traditions. Many war-time reserve officers believed too much attention was given to "spit and polish" and not enough to professional development.

Low priorities assigned to construction for medical facilities was a cause of trouble. The result in one case (Subic Bay, P. I.) was the carrying on of "a large volume of medical work in a filthy, practically impassable morass during the rainy season, while at the same time an elaborate officers' club was built and operating".

During the war there was a tendency on the part of some districts and group commands to encroach on the independence of hospitals under their military jurisdiction."****

RECORDED

L. K. Pohl
L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Brig. Gen. Robert C. McDonald, MC, USA, (Ret.)
dated 15 April 1948)

***** "(j) General Relationships with other branches of the Armed Services relative to medical planning and requirement.

"(1) Comment: Medical planning must be coordinated by representatives of all the Armed Services. Requirements in personnel and material must be coordinated so as to promote team work." *****

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT
HISTORICAL RECORDS OF WORLD WAR II. (Ltr. fr Brig. Gen. Malcom C. Grow,
Surgeon USSTAF, 11 March 1945 to Brig.
Gen. Charles R. Glenn, DAS)

***** "In relation to planning for a postwar medical service, it would seem to me that you should endeavor to obtain as much control of your personnel from top to bottom as possible. In the RAF setup, Air Marshal Whittingham has direct control of his personnel at all times, and can move personnel from one post to another, promote them as he sees fit, and is not interfered with by intermediate Air Corps commands, as is the case in our setup. In this Theater, once an officer is turned over to a command you have practically lost all jurisdiction in relation to administrative matters and a considerable amount in relation to professional technical details. This is due to the fact that in certain Air Forces everything has to go through command channels, and technical channels are cut out entirely in some cases and greatly minimized in others. Whether you call it a 'medical command' or 'medical service' would appear to be immaterial except that the former implies command prerogatives and if it could be put through the War Department I believe that term would be desirable. What with T/Os and other administrative difficulties, the position of the Flight Surgeon in the lower echelons is most unenviable, and a great many men with a lot of ability are not receiving their just rewards. It is impossible, when one understands human nature, to expect that the Air Corps will sacrifice chances to promote Air Corps officers in order to promote Medical Corps officers, and when the medical officers are mixed up in a common T/O, Manning Table, or Bulk Allotment, there is nothing that the higher medical Hq can do to help them. In this respect, I believe that there should be an elevation of one rank in squadrons and groups. In other words, the Group Surgeon should be a Lt. Colonel and the Squadron Surgeon should be a Major on the T/O."*****

(Ltr to: Whomever it May Concern dtd 6 Feb. 1943 unsigned (submitted by Colonel Robinson but probably prepared by Maj. Rergeman)

***** "Having arrived in this theater with complete ignorance as to the conditions and problems that would confront us, many attempts were made, both through medical and command channels, to improve the health of the command. It is felt that too many high ranking officers in the higher echelons, who are totally lacking in the proper perspective and knowledge of the problems which confront tactical units, occupy the various positions. Much correspondence, channels, and generalized 'red tape' succeed very successfully in bogging the matter down completely.' It is recommended that, before being placed in higher echelons, officers spend sufficient time in the field in order to have a true grasp and picture of conditions as they are.

RECORDED



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT
HISTORICAL RECORDS OF WORLD WAR II. (324 Sq. Grp., Observations of Major
Jesse F. Harritt, MC)

***** "On September 18, 1943, the dispensary was combined with the squadron and moved to Djebel Oust, Tunisia, near Tunis. Here at this point medical functions were almost nil Morale ran low. The old spirit of being a unit of which men were proud had disappeared. From a useful medical dispensary which was referred to by all members of the Group as 'the hospital', the section had become to be known as 'the medics'. Gradually the men became more restless. Transfer requests were many. Two men became chronic alcoholics. This situation was brought about by the new commanding officer, who knew nothing of medical problems, but always took an antagonistic attitude and seemed to enjoy belittling the medical profession in general."***** (11th Air Dep. Gp.) - Major Samuel Fertig's (Sq. Surgeon) complaint.

***** "Due to the drastic reduction of Squadron T/Os considerable difficulties and inconveniences have arisen which are incompatible to the proper performance of Aid Station duties. A typical example is that of Supply Squadron which is complemented with one ambulance driver (private) and two medical technicians (Pfc and Corp.) In addition to their duties as medical technicians it is necessary for these men to take care of all clerical and charge-of-quarters duties. This of course overtaxes the work of the Surgeon, as well as the enlisted men. It may be well to mention also that the withholding by the Squadron of the proper medical T/O ratings which would promote the technicians to Corporal and Sergeant respectively, is a morale factor which is most certainly not conducive to the best interests of the Medical Section. The men, Pfc. Robert Grosse and Corporal Lowell Bromberg are experienced and valuable technicians who, not unnaturally, feel slighted and dispirited because of the Squadron Commander's refusal to comply with the Surgeon's recommendations for promotion. Apparently the only reason given for non-compliance is unavailability due to the belief that the work of the regular squadron personnel is of greater importance.

"These instances have arisen quite frequently throughout the entire period of overseas history and have oftentimes proven very difficult to combat. It is the opinion of this writer that if Medical Section T/O's were legally classified as inviolable and distributable solely upon the recommendations of the responsible Surgeons, it would do much to increase the confidence and pride in the Medical Department which is so necessary to attain the desirable exacting performance of enlisted personnel."*****

RECORDED
L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT
HISTORICAL RECORDS OF WORLD WAR II. (19 Sq. Gp.)

***** "Under the present method of administration it was found that
the Medical Officer had no control over medical personnel. The head-
quarters squadron commander was responsible for the administration of
medical personnel. When men were needed for outside details it was not
at all unusual to call for medical personnel to perform their duties."

RECORDED*L. K. Pohl*

L. K. Pohl, Colonel, MC**RESTRICTED**

RESTRICTED

TRUE COPY EXTRACT (LTR DR. H.S. HOFFMAN, DTD 13 MAY 48)

***** J. "One glaring weak spot in Medical Department operations during military campaigns in the Pacific existed throughout the entire period of hostilities. It was probably responsible for more failures of the Medical Corps than any other single factor. It caused increased loss of life and delayed certain operations by producing large (but preventable) man-day losses due to illness. Reference is made to a common practice of Commanding Officers (Line) of refusing to accept recommendations of their medical staff in the planning stage, or, during operations to permit prompt execution of plans previously approved. One notable exception is described to emphasize the general rule. During the staging period for the operation in the Marshalls one prospective Island Commander gave his base surgeon a carte blanche in the matter of preparing for medical operations including sanitation and burial of Jap dead. On arrival on the island, he continued his absolute support of medical operations and would tolerate no interference from any source. As a result, when Admiral Nimitz arrived on the island on D7 or 8, he found burial of the Jap dead practically complete and the general sanitation of the island so far advanced that he gave the base surgeon a "well done" on the operation. It is believed that more suitable action on his part would have been the award of a decoration to the Island Commander. What had been accomplished by the Medical Department was due almost wholly to his complete cooperation. Apparently some attempt has been made to improve this situation, by recent changes in regulations. Obviously the sound principle of unity of command in the field creates difficult problems in this regard.

More than one medical officer - especially Reserve - came to grief in the futile attempt to persuade Line Officers to permit the execution of vitally necessary medical operations. I believe this situation is well known to the Medical Department. One wonders, therefore, why medical officers in this position have failed to receive sympathetic consideration from medical superiors. If a medical officer refused to modify his factual reports of the obvious medical deficiencies of his operation on direct orders from his Commanding Officer, he became persona non grata with him. He got a poor fitness report and/or a transfer to other duty. If he complied with his commanding officer's orders and modified his report, he tacitly assumed the responsibility for failures not properly his own. In either event he wound up behind the eight ball with the Medical Department despite the fact that his medical superiors were cognizant of the circumstances; many of them having been in the same position - no doubt.*****


L.R. FOHL, MC. COLONEL

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain O. B. Morrison, Jr., MC, USN
dated 23 April 1948)

***** "j. General relationships with other branches of the armed services relative to medical planning and requirements.

Administrative officers of all the branches involved should meet and discuss the planning and requirements. There will be few problems that cannot be solved when each member feels that all involved branches understand what the problem is."*****

RECORDED

L. K. Pohl
L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT FROM AIR EVALUATION BOARD SWPA REPORT NO. 35. THE MEDICAL SUPPORT OF AIR WARFARE IN THE SOUTH AND SWPA FROM DEC 7, 1941 TO AUGUST 1945.

***** J. "Not infrequently a high morbidity rate, which threatened the operational efficiency of a unit and the success of a planned operation, resulted from the failure to implement preventive measures. It was apparent that in most instances the recommendations of the Unit Surgeons were not implemented by command personnel of all echelons. These commanders failed to appreciate their responsibilities in the maintenance of the health of personnel in their command.

The majority of Air Force troops did not maintain a good nutritional state during the course of the war. The main reason for this situation was the fact that personnel refused to eat a large portion of the food served to them. In addition, the nutritive value of the ration as issued was frequently inadequate. Poor preparation of food by mess personnel was primarily responsible for the nonacceptability of the ration. Lack of variety in the ration as issued and the dislike by personnel for certain types of food were also responsible. The poor preparation of food commonly encountered was a direct result of the assignment of both officer and enlisted personnel to mess duties who were not qualified for the job. Field instruction of this personnel was instituted and proved to be an efficient method of increasing the palatability of meals served to Air Force troops. The effectiveness of this instruction was limited by the lack of authorization for instructor personnel and equipment."*****

RESTRICTED

L. K. Pohl
L. K. POHL, COLONEL, MC


RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C. B. Cameron (MC), U.S.N.,
Retired dated 21 April 1948)

**** "(j) The closest possible cooperation and liaison must be established and maintained with the employment of interchangeable and uniform equipment throughout. This factor is considered as most important. Equipment and supplies for ALL branches of Medical activities should be identical insofar as their respective missions permit."****

TRUE COPY EXTRACT FROM AIR EVALUATION BOARD SWPA REPORT NO. 35. THE MEDICAL SUPPORT OF AIR WARFARE IN THE SOUTH AND SWPA FROM DEC 7, 1941 to AUGUST 1945.

***** J. "The full potentialities of the medical services were not attained because the majority of command personnel of all echelons did not appreciate the extremely important relationship between preventive medicine and operational efficiency."*****


L. K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Arthur B. Welsh, MC, USA
dated 19 April 1948)

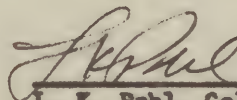
***** "j. Each service did its own planning and came up with its own requirements. Jointly established tables of organization and manning tables were noticeably absent. The Navy required more doctors per over-sea fixed bed than the Army. One agency didn't exist to review these requirements and reconcile discrepancies. There was too little joint medical planning. Flexibility in planning so essential to enable step-ups or cut backs or intra-service transfers of facilities, personnel, or equipment was lacking. There wasn't one procurement agency. This could all have been tied up in an Armed Service of Supply organization provided there had been intelligent medical leadership. This would have required an individual who knew military and civilian medicine and to whom the responsibility for the efficient operation of medical activities had been delegated. Such an individual would have needed both responsibility and authority and could not have been hamstrung as The Surgeon General of the Army was in the ASF organization in World War II." *****

TRUE EXTRACT COPY (Ltr Cndr Martin T. Macklin (MC) USN dtd 12 May. 48.

***** J. "However, to avert past operational errors the staff Task, Squadron, Division, Group and Unit medical officers must be considered as integral and essential members of The Operating Forces, regardless of his rank with full knowledge of the mission to be performed and not be considered merely as an accessory, to "dove tail" in the Operation Plan at the behest, or in accord with the whims and wishes of the line members of the joint staff or staffs. The Medical Annex must be considered in the same strategical light as the other annexes of the Operation Plan."*****

RESTRICTED

628



L. K. Pohl, Colonel, MC

RESTRICTED

TRUE EXTRACT PT OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - APTAS.

***** J. "Personnel Problems and Policies. The medical reports from the European Theater of Operations up until the closing months of hostilities almost invariably make some reference to the shortage of medical and dental personnel. Correspondence to and from the Office of the Air Surgeon attest the existence of this problem along with a sense of despair in the efforts being put forth to remedy a situation due not only to an inadequate supply of doctors and dentists but to the fact that those available were inadequately trained to cope with the problems introduced by aerial warfare. The lack of understanding among higher authorities in the theater and in the War Department of the medical problems encountered by the Air Forces contributed to the difficulties of those responsible for the health and efficiency of fliers. The inflexibility of the rules and regulations prevented on numerous occasions and under various circumstances the full utilization of the medically trained personnel in the theater. The assignment of medical officers to routine duties unrelated to their previous training and experience, discriminations against them in matters of rank, poorly defined and executed leave and disposition policies - all combined to make the administration of the Medical Department a task envied by no one.*****

L. E. FOHL
L. E. FOHL, Colonel, MG

J. CONTINUED

The importance of keeping the office of the Air Force surgeon in direct contact or access to command channels had been overlooked. As a result, the channels of communication became clogged and the Air Force surgeon lost immediate contact with the tactical units to which a considerable part of the medical personnel was assigned.

In relation to planning for a postwar medical service, it would seem that you should endeavor to obtain as much control of your personnel from top to bottom as possible. In the RAF setup, Air Marshall Whittingham has direct control of his personnel at all times, and can move personnel from one post to another, promote them as he sees fit, and is not interfered with by intermediate Air Corps commands, as is the case in our setup. In this Theater, once an officer is turned over to a command you have practically lost all jurisdiction in relation to administrative matters and a considerable amount in relation to professional technical details. This is due to the fact that in certain Air Forces everything has to go through command channels, and technical channels are cut out entirely in some cases and greatly minimized in others. Whether you call it a "medical command" or medical service, would appear to be immaterial except that the former implies command prerogatives and if it could be put through the War Department I believe that term would be desirable.*****

L. E. FOHL
L. E. FOHL, Colonel, MG

RESTRICTED

RESTRICTED

Extract of Statements made by Brig Gen Robert C. McDonald, MC, USA (Retired),
21 April 1948, before the Subcommittee on the Employment of Military Medical
Resources.

***"General Relationships with other branches of the Armed Services relative
to medical planning and requirement."

"Medical planning must be coordinated by representatives of all the
Armed Services. Requirements in personnel and material must be coordinated so
as to promote team work."

Now, I didn't give very much comment on that. I think it's pretty evident
to all of us that we know that we must have cooperation and coordination of the
medical services of the various branches of the armed forces. I think we had
that to a very large extent in World War II. I don't think we had it to the extent
that we should have it.

I believe there should be some over-all planning wherein there will not be over-
lapping in the medical services any more than we can possibly help.

In my comments I have said very little regarding how the medical services
of the armed forces can be welded and unified. I haven't given that enough
thought to make any comments worth while. However, I feel that they will co-
operate and that they will be unified to a certain extent in those things where
they can.

Brig. Gen. McDonald: I think that is an excellent proposal. Certainly the
Joint Chiefs of Staff should have the advantage of the advice of highly-trained
men from the various medical departments when any war plan is under consideration.

I don't know just exactly how you would implement that. The idea of a
board with representatives from the various medical services I should think
would be the proper way. I think it's a good idea.

Brig Gen McDonald: I am very heartily in favor of providing for medical
staff representation throughout all echelons of the armed forces.

I think in the last world war when the medical services of the corps
areas or service commands were reduced in level so that they became assistants
to a supply director, it was bad. Fortunately I had no difficulty with that
matter because the Director of Supply of the Third Service Command told me
to carry on just the same as I had with him and the Commanding General, but from
what I heard that did not pertain in all service commands. I don't think we
should have any plan that's going to depend upon personalities, and I think
that that one did depend a good deal on personalities, because if somebody over
the surgeon, or the surgeon himself, did not have just the right slant on it,
the medical service of the service command suffered.

I am heartily in favor of having some sort of a firm policy established on
that. I think that's correct.

RESTRICTED

RESTRICTED

"Would more autonomy of the Surgeon Generals prevent much of the confusion that now exists in personnel control by G-1?"

Yes, I think it would. I think that the Surgeon General should have considerable control over professional and specially -qualified personnel used by their services.

"What is your opinion of the value of using the Surgeon or another medical officer as a member of the G-4 staff? Should he be a liaison officer of the surgeon or a consultant assigned to G-4?"

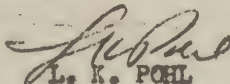
I think he should be separate; and he should have the same access to the commanding general that G-4 himself has.

"Do you consider it imperative that the surgeon be included from beginning to end in all planning in the armed services/"

Yes.

"Should the surgeon keep liaison officers on all sections of the general staff? If not, why? Would they be accepted, in your opinion?"

I don't think I would locate medical officers in the offices of a general staff, as a general policy. There might be instances in which it would be valuable. But if there is the proper relationship and spirit of coordination and cooperation between the general staff and the surgeon general, there is no difficulty in keeping track of all that is going on."*****


L. K. POHL
Colonel, MC

RESTRICTED


RESTRICTED

TRUE EXTRACT COPY: (Extract of statements made by Colonel Thomas J. Hartford, MC, USA on 23 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

**** "j. In the theater that I was in we were afforded from the very beginning an opportunity to be in on all the planning. We were given all the information that anyone was given on the mistakes and planning generally. There were some staff organizations that made it a little difficult for us to operate -- and I am speaking then of the theater--but perhaps somewhat due to the personality of General Hawley, we certainly couldn't kick much on information we were given.

I would say liaison, not autonomy. I still think there has to be a P&A section myself, and I think they have to run it, and I think it would be worse if we had it entirely under our control. I might go to Siberia for that.

I think we do need good coordination, and I think that the next war when the Personnel Division--I am speaking of only Army now--comes to the Surgeon General's office and says, "How about giving me some hard-working lad to help advise me and coordinate with me," that our answer shouldn't be as I know it was in the last war, "We can't spare one man." We ought to give him that man and then we would have the coordination. ****



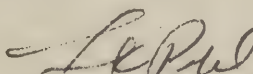
L. K. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain W. D. Small (MC), U. S. Navy
dated 5 May 1948)

***** "10. The medical section of CinCPac's staff was composed of personnel from all the Services. It operated as a closely cohesive unit with a single common aim. The most cordial and cooperative spirit, both official and personal, was maintained. It is my opinion that it was the most effective joint medical staff in the Pacific. There appears to be no good reason why future planning, requirement and implementation cannot, under proper leadership, be accomplished in like manner. However, such effectiveness cannot be developed unless "empire building" by one branch of the Armed Services at the expense of another branch is prevented. The medical departments of the Armed Services having as they do a common profession governed by high ethical principles should do a better job in this respect than other branches."*****



L. K. Pohl, Colonel, MC

RESTRICTED


RESTRICTED

TRUE EXTRACT COPY (Ltr Lt Col W.J. Reuter, Dental Corps, dtd 11 May 48)

***** J. "Responsibility of Dental Officers. a. Deficiency - Under the present organization of the Medical Department dental officers do not have responsibility of the dental service and make decisions regarding dental matters subject to the approval of the Surgeon. Since the Surgeon has final responsibility, if of necessity follows that final decision, also in dental matters, must rest with him. The Dental Corps has gained much in its association with the Medical Corps. Generally it is believed very amiable relations exist between surgeon and dental surgeons. Furthermore, the Dental Corps without a doubt has benefited again and again by wise decisions of the Surgeon in matters pertaining to the dental service, particularly during the war when there was much untrained personnel, including dental. On the other hand, it is believed the dental officers generally feel that decisions by surgeons regarding dental matters are at times contrary to the desires of the dental surgeon and contrary to the interests of the dental service; such decisions being made because of lack of knowledge or understanding of the dental situation, because of personal dislike to the dental surgeon, to make his authority felt, and the like. Practices of this nature certainly are not the rule but the exception. Also dental officers are not staff members and dental matters are presented and discussed, not by the dental surgeon but by the surgeon.

b. Unfavorable Effects - The chief unfavorable effect is believed to evolve upon the dental officers themselves and upon the dental service as a whole, and results from the position the dental service occupies within the Medical Department. Serving under a Medical officer creates in the dental officer a feeling of being supervised by a comparatively disinterested individual. Even if interested intensely, there still arises the question whether the surgeon will understand since dentistry as a profession is so highly specialized that only a dentist thoroughly understands dentistry. Dental matters to be discussed at staff meetings are presented by the surgeon while the dental surgeon with detailed knowledge of the situation remain absent. Pertinent military matters may come to his attention second hand or not at all. The surgeon gains in administrative experience through his attendance at staff meetings while the dental surgeon is denied this. Subsequently, he suffers embarrassment because of his lack of administrative experience. Present regulations permit the dental surgeon a direct approach to the commanding officer of the base in case of disagreement with the surgeon regarding matters of dental policy. However, to take advantage of this privilege just once could surely terminate all amiable relations that may previously have existed. With all this in mind, there evolves a feeling of inferiority upon the dental officers which breeds insecurity, discontent, lowered morale and an inferior dental service.

RECOMMENDATIONS: That such changes be made in the organization of the Medical Department as will give the dental officers responsibility of the dental service, make the dental surgeon a member of the base and/or headquarters staff, and give the dental surgeon control of dental enlisted personnel.*****


L.K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

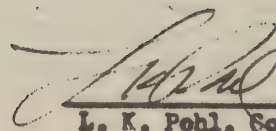
TRUE COPY EXTRACT (Letter, Colonel O. F. McIlroy, MC, Air Force
dated 20 April 1948)

***** "j. The undersigned experienced no difficulties in general relationships with other branches of the Armed Services relative to medical planning and requirement. It is understood, however, that such difficulties were encountered, and it should be impressed upon the chiefs of all services that there cannot be any proper medical planning unless those responsible for the medical services are fully informed at all times." *****

TRUE EXTRACT COPY (Ltr Brig. Gen. G.R. Kennebeck, Dental Corps, dtd 7 May 48)

***** J. "Training schedules of all branches of the Armed Services should be so arranged that there are some periods when individuals could receive dental treatment without falling behind in the instruction being given. In World War II a number of individuals undergoing school courses neglected necessary dental treatment because they feared absence from instruction might jeopardize their chances of graduating with their class."*****

RESTRICTED



L. K. Pohl, Colonel, MC

RESTRICTED

**TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE MEDITERRANEAN THEATER
HISTORICAL SECTION - AFTAS**

***** J. "The Surgeon is responsible as a staff officer to the Commanding General, Army Air Force Service Command, Mediterranean Theatre of Operations, for Medical activities of all organizations assigned or attached to the command; and he is responsible to the Surgeon, Army Air Forces, Mediterranean Theater of Operations, for medical administration of all major echelons personnel.

In practice, however, only in regard to malaria control, medical reports, and medical supply procedures for depots was directive action taken with respect to all these high echelon organizations; in other matters for the most part the supervision was advisory in nature. For example, the dental and veterinary activities in the Ninetieth Photographic Wing Reconnaissance and the Army Air Force Engineer Command were supervised in the same manner as those of Army Air Force Service Command units, while the Twelfth and Fifteenth Air Forces remained practically autonomous with respect to these two functions.

The Surgeon, Army Air Force Service Command, was made the Air Force technical channel to and from the Surgeon, North African Theater of Operations, and the only Air Force supply channel in the Mediterranean Theater, to and from the Zone of Interior. Also normal command channels concerning monthly sanitary and venereal reports were altered. These reports were submitted by all Air Force units in the theater to the surgeon, Army Air Force Service Command, and unless they were deemed to be totally unsatisfactory or for other reasons to require the attention of the Surgeon, Army Air Forces, Mediterranean Theater of Operations, they were returned to the unit of origin for correction or compiled and forwarded to the Commanding General, North African Theater of Operations, without further reference to the Commanding General, Army Air Forces, Mediterranean Theater of Operations.

The high incidence of intestinal diseases in the Twelfth Air Force for 1943 was attributed to two main factors: a lack of supplies and a lack of experience and information on field conditions. Wire screening and lumber to build sanitary mess halls, latrines, and other facilities were not available. Nor were insect spray materials and sprayers in supply. Whatever improvisations could be made fell far short of actual need. Meanwhile, directives were issued containing information on these diseases and outlining the necessary sanitary measures to be instituted. By April 1944 adequate supplies of screening and spray materials were available. With the screening of mess tents, mess halls, and latrines, and the institution of other sanitary practices, the general level of sanitation was greatly improved. This improvement in sanitation included many of the small Italian towns near Air Force installations. Although the results of the sanitary program could not be evaluated as early as June 1944, it was considered pertinent that no significant increase in intestinal diseases occurred in May 1944. A comparison of the annual rate for May 1943 with that of May 1944 shows that the former was 102.1 per thousand while the latter it was 28.4.*****

RECORDED

L. E. POHL
L. E. POHL, Colonel, MG

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT FROM PREPARED STATEMENT SUBMITTED BY CAPTAIN LOUIS H. RODDIS,
(MC) USN 10 MAY 1948.

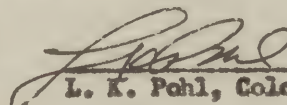
"Professional and Military Emergency Training Programs Within the Armed Forces.

"I believe one of the most important things which the Medical Department could do would be to bring into the teaching program of all line schools from the War College level through the Naval and Military academies, and various special arms schools the great importance of the organization of military medicine in the winning of campaigns and wars. A carefully prepared teaching program should be elaborated to train and indoctrinate the line officer with the knowledge that military medicine is as important in winning a campaign of war as artillery or infantry; in other words, that military medicine in modern war is a military weapon.

"The evidence of course is clear and convincing. It can be shown from many viewpoints. Examples are innumerable in military history showing the success or failure of campaigns due to lack of military medical resources and organization and also the proper employment of military medical organizations. World War II is full of evidence of the decisive effect on campaigns.

"At present there is a lack of this critical knowledge on the part of military commanders. The importance of not only the care and evacuation of the sick and wounded, but the effect of preventive medicine on the success or failure of military operations is not well understood by nonmedical military men, and no real program for instructing them has ever been planned or carried out. Several new types of warfare that are now appearing on the horizon make the need for a knowledge of the importance of military medicine in the Army, Navy, and the Air Forces still greater.

"Such a task would not be easy. First, it would have to be explained, justified, and sold to the highest authority in order to plan and place such a program in effect. The lack of texts and of competent instructors is perhaps the greatest handicap. Military medical men have not, in the past, indoctrinated the combat officer with the value of military and preventive medicine as a necessary arm to secure victory. I believe one of the greatest contributions we could make would be to introduce the proper teaching of military medicine from the strategical and tactical viewpoint in the Military and Naval Academies, the War College, in every staff school, and in the training courses of all military services and arms."*****

RESTRICTED


L. K. Pohl, Colonel, MC

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** (J) I believe there should be a Joint Medical Planning Board of all services concerned on the level of the Joint Chiefs of Staff.

"1. No. In some instances medical staff officers aren't even advised of the contemplated operations or included in the planning phase.

"2. I don't think there should be a surgeon or medical officer as a member of the G-4 staff.

"3. I think it is absolutely necessary.

"4. I don't believe it is a good idea. I don't think they are necessary in all G-4 staffs."*****

*****"6. I do not believe that full consideration was given to all aspects of medical support by Joint Staffs during the planning phase. I think that as a rule, there was cooperation between the medical services. I think the overall plans worked out in practice. I think that failure, when it did occur, was because of the different administrative set-ups in the medical services, particularly with regard to logging of sick and wounded. Re difference of importance - there was at first, but after staff officers were indoctrinated they had a better understanding of our problems. It was mainly lack of understanding on the part of line officers."*****

***** "9. Direct communication between Chief Surgeons of Joint Forces was not encouraged and it was not permitted. ~~It is very desirable.~~"*****



L. K. Pohl, Colonel, MC

RESTRICTED

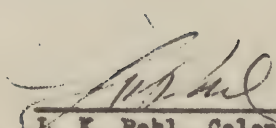
RESTRICTED

TRUE COPY EXTRACT (Letter from Rear Admiral A. H. Dearing (MC), USN
dated 26 April 1948)

***** "(j) General relationships with other branches of the Armed Services relative to medical planning and requirement.

The relationships between the Medical Departments of the Armed Services in the South Pacific area were at all times excellent; cooperation was of the highest order, and the joint utilization of facilities where necessary was never questioned by any service. Although no firm policy for cooperation and coordination had been laid down from the higher level of Navy or War Department, in the actual field operations within the combat and communication zone of the South Pacific area, there was never any friction between the medical components of the services nor was there, at any time, any questioning of the authority and position of the medical officer on the staff of the Commander of the area who was the Senior Naval Officer." *****

RESTRICTED


E. K. Pohl, Colonel, MC

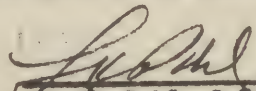
RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. R. Urban (MC) USN
dated 28 April 1948)

***** "(j) General relationships with other branches of the
Armed Services relative to medical planning and requirement.

"(1) Close liaison with other branches of the Armed Services
is essential.

"(2) Administrative difficulties and reports associated with
cross-hospitalization between services will have to be solved and
standardized." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Dr. Howard A. Rusk dated 22 April 1948)

***** "I feel, too, that there is a necessity for the continuation of a medical board at the level of the Secretary of Defense for the purpose of formulating policies and programs of the Medical and Hospital Services of the armed forces. Such a board, consisting of the three Surgeons General, it seems to me would be greatly strengthened if three civilian consultants could also serve. I feel that such a constituted board would make for better cooperation all round." *****

RECORDER

L. K. Pehl

L. K. Pehl, Colonel, MC

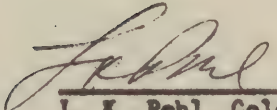
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Karl Maxwell, MC, Air Force
dated 19 April 1948)

***** "8. The Medical Department was dependent upon someone for constructing and, therefore, on many occasions materials set up for hospital construction were diverted to other uses. On the island New Georgia, one hospital commander had a homemade ice cream manufacturing plant and was forced to trade ice cream for nails, lumber, tentage and other necessary items. This was only one of thousands of cases where the hospital had to trade something they had in order to better their conditions." *****

RESTRICTED


L. K. Pehl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain W. C. Baty, Jr., (MC), USN
dated 19 April 1948)

**** "The assignment of medical officers to the staffs of the higher echelons of command afloat and allowing them to participate fully in the planning phases of the operation at their various levels, and by giving these officers rank commensurate with their responsibilities. Only in the last few weeks of the war were medical officers assigned to the top staffs afloat. The command responsibilities at the various levels for the evacuation of casualties can be more adequately accomplished if the recommendations of these staff medical officers are fully considered.****



L. K. Pehl, Colonel, MC

RESTRICTED

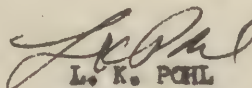
RESTRICTED

Extract of Statements made by Brigadier General Raymond Dart, MC, 29 April 1948 before the Subcommittee on the Employment of Military Medical Resources.

*****"There are many things that we ran into in our theater that probably were entirely different from anything that happened elsewhere, that were of serious consequence and a serious handicap; and the No. 1 thing was lack of planning on the GHQ level right down in SOS without any knowledge; come down and say, "How many hospitals are you going to need in New Guinea?" "Well, how many troops are you going to have in New Guinea, or any where you are going to fight?" "We can't tell you that. That's a secret."

It's as ridiculous as that, and we were planning in the dark. I planned 50,000 beds, more or less—that's just a rough estimate—in Brisbane under orders of the Chief Surgeon and we had no idea of putting a base in there. We weren't going to evacuate there. And there are things of that kind that should be correlated.

Now, it may be in the other theaters it was entirely different, but ours was a peculiar setup. Those are things that might be of value to this Board."


L. K. POHL
Colonel, MC

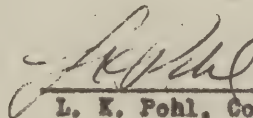
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M. J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

***** "(j) General relationships with other branches of the Armed Services relative to medical planning and requirement.

These to the extent of my knowledge, were good and based on sound factors. Line commanders were well aware of the importance of medical services and in many instances contributed greatly to their efficient operation. This was true of the army service as well as those of the navy. Personal relationships were maintained at a high level. These relationships between army and naval medical officers resulted in a realistic appraisal and understanding of our common needs and responsibilities. We shared what we had with each other, and I know of no conflict or misunderstanding of any importance which existed between the medical services of the army and those of the navy. The medical profession may well be proud of this fine relationship of which there were innumerable instances."*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel F. A. Blessie, MC, USA, dated 19 April 1948)

" **** 10. General relationships with other branches of the Armed Services relative to medical planning and requirements.

"a. In staff planning, emphasis is naturally and rightfully on the combat arms. The more experienced officers, however, are equally aware of the need for proper technical support and in general are more likely to provide for it than the younger, less experienced officers, or those who did not have extended combat duty. Every effort should be made to indoctrinate this latter group with the hopelessness of a combat situation that is not adequately supported by technical troops. It is essential, however, that all services coordinate their requirements with the military situation and that primary consideration be given to the combat elements.

"The devastation of the next war will confront commanders with medical problems of considerable magnitude. They must be thoroughly aware of the importance of special training for selected medical officers for high level staff and command positions. At present, there are not enough spaces authorized the Medical Corps for such training at the National War College. This year none was authorized and next year but one. Such training should be progressive and should include assignments in higher staff positions to insure proper selection for high level training in the special field.

"b. Close collaboration between the medical services of Army, Navy, and Air Corps, and with other branches, is most essential if proper medical planning is to be effected.****"

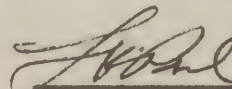
RESTRICTED


L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain C. D. Middlestadt, (MC) USN
dated 17 April 1948)

***** "In reply to paragraph 3(j), my experience with other branches of the Armed Services especially the Army Medical Department is one of the highest praise. Their supply table seemed to have everything that any medical man could want, and they were always willing to loan or give me anything I needed without any reservations. Their attitude was that we were all a part of the United States and that we were fighting the same cause and that what they had was for the use of the sick and wounded regardless of uniform. Their hospitals were open to our needs. They supplied planes for DDT Spraying in our area. In the Samar - Leyte Area the Army Commander seemed to assign the hospitals to the least desirable areas. All their hospitals were located in low swampy areas. This has nothing to do with relationship of the Army, but I wish to state that all the planning done by the Medical Department concerning high ground, good drainage, etc., can be wrecked by some area commander without recourse. The Army's attitude of a ruddy existence in the field should not apply to the sick and wounded. I know that one Army Commander would not allow his medical officers floors in their tents to get out of the mud. In one case our Navy Sea Bees wanted to show their appreciation to an Army Medical Officer and placed a floor in his tent. He was forced to remove it by the area commander and to live in the mud. To me, such things are petty, but they are not morale builders when we ask these physicians to join the reserves."



L. K. Pohl, Colonel, MC

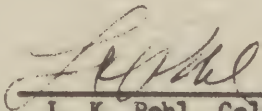
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Robert E. Peyton, MC, USA
dated 19 April 1948.)

"****4. Teamwork. I feel that the Medical Department cannot exist alone as a separate entity. It must be part of a team. It is dependent on all the other technical services; for example, on the Quartermaster for rations and laundry, on the Engineers for engineering assistance, supplies, and labor, on Ordnance for vehicles, on transportation agencies for that service, and on the Signal Corps for Signal communication. It cannot exist without these things. If the Medical Department is separate it must have these technical services as well as the administrative services for its own or be forced to procure them from some other agency - if and when that agency can spare them! The danger of the latter condition is obvious. The gigantic administrative task of caring for approximately ten percent of all personnel of a large theater of operations, including patients and medical personnel, must be regarded as a major task in itself. Further, the medical service must work in the highest degree of mutual interdependence and harmony with the field force it supports and in types of organization patterned parallel to the force supported. To do this it must belong.

"The conclusion is reached that if the medical service is placed on National Defense level it must either be provided with its own technical and administrative services, or all technical and administrative services must be placed on the same level. In the former case it amounts to making a medical service in addition to the Army, the Navy, and the Air Force. In the latter case it amounts to placing all technical and administrative services on National Defense level and creating a common pool for service to the Army, the Navy, and the Air force. In either case the administrative and management responsibilities and difficulties of the unified medical service will be greatly increased. In either case effective results will only be obtained by a decentralization of the great bulk of operating functions with the retention of supervision, coordination, and a few carefully selected operating functions at the highest level. Perhaps the initial procurement of professional personnel might be regarded as a desirable centralized operating function."****"


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic A. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

***** "I feel that whether the Army General Staff System is good or is not good—which of course it's not for me to say—nevertheless that is what we have, and as long as the Army is set up to operate a certain way, I feel that the Medical Department, as part of the Army, will do a lot better to form itself into the team; and by learning what that team is and how the team functions, under what rules it functions, the Medical Department can do a lot better than it can by feeling that the Army is merely a hindrance and holding us back in our professional efforts."*****

"As far as overcalling of medical officers is concerned, that can be at least reduced considerably by a better knowledge on the part of the Surgeon General as to what the over-all strategic plans are. If he is permitted to know sufficiently in advance, he can then intelligently request medical manpower at the right time and not be scared into or bribed or bullied into getting a lot of people in long before they are needed. That's a question once more of getting the medical people into the over-all planning activities at every echelon."*****

"My experience and all my training has been to the effect that medical people have continually had to drum and pound and emphasize and fight for adequate medical support for an operation. It seems to be in the nature of a fighting man that he never seems to want medical service until he wants it right now, and then he wants it right now without having planned for it or permitted it to get there.

"I further state from personal knowledge that the staff officers and commanders who argue most against cluttering up their ships with medical units and permitting an adequate medical service to go on an expedition usually seemed to be the ones who cry the most when they get hurt and expect the most out of the medical people that are present for duty.

"In answer to (J) 2, my personal opinion is this: when you can't have close contact a liaison officer is a fine thing. He is definitely next best to promote contact between staff agencies. The desirable situation is where the medical section and the G-4 section have continuous friendly understanding contact. If you have to take a trained medical officer from your section and put him in somebody else's section, you merely weaken your section by that body, or by the number of bodies you have to take out. There certainly are times when liaison officers are probably advisable, but they shouldn't be necessary in the headquarters of a unit."

REC-1

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic B. Westervelt, MC, U.S.A., on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

"I have already answered No. 3, and I will answer it again. The surgeon of any command at any level should be in on the first planning regardless of how fragmentary those plans may be released, and should be kept in the middle of the planning until the operation is completed.

"I have answered No. 4. This is entirely based on my opinion. It may be that I have been lucky in having understanding staff officers to deal with, or maybe I have been able to sell myself better than some medical officers, but I have never seen any indication for taking officers and putting them in general staff sections."*****

"Cooperation between the involved medical services was definitely the rule as far as my experiences were concerned. I can't think of anything that worked better than the cooperation among the several medical services in our part of the world.

"There is definitely a difference in importance or weight given medical service by the various armed services. I speak with feeling on this. The Marines in particular have a type of pride which indicates that they don't need any particular medical service. They are too tough to suffer when they get hurt, and they feel that the medical service beyond a little patching up is just a waste of time and shipping space. And in my opinion the Marines are just like everybody else.

"As far as medical or line officers are concerned, I think if you just take them all, take all the medical or line officers and lump them together, it's about even. The noticeable difference, I repeat, was in the Marines, which was very interesting to observe the attitude, and it resulted, of course, in a considerable rapid and dangerous lowering of the morale when they found they were getting hurt and weren't getting the attention that they ultimately came to believe they would like to have.

"(J) 7. As far as No. 7 is concerned, joint use of all medical facilities was encouraged and was a fact in the areas in which I participated; had to be.

"Practical difficulties in administration were pay, medical records, forms for emergency medical tags, and forms for disposition of the remains. They were the ones that you would expect to present difficulties, and for the most part are presently on the way to being resolved. Standard forms have been prepared and are being tested at several places right now."*****

"(M) 3. I do believe the accepted notion that troops respect and have confidence as a result of association. I also know from the standpoint of the staff relations, and also to get back to this important planning angle—you all know this very well—that if the doctor has gone through

RESTRICTED**RECORDED**

650

L. K. Pohl, Colonel, MC

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

things with these line officers, gone through the schools with them and associated with them, that they have a feeling for them that they never have for a man who has professional ability by reputation. If it has been demonstrated with them, they will respect him, but just because a man is a good doctor doesn't get him the cooperation. It doesn't get him the look-in on the staff planning unless he has associated with these people, unless he knows them, eats with them and is friendly with them and shows them that he is one of them and is part of the game.

"I know from my personal experience that I have gotten more, and I think every doctor has gotten more, out of his combined schools, the line schools, far more than the tactics he has learned. He has made the association, he has made the friendship of the members of his classes, and that association pays big dividends all the way through the rest of his service.

"You lose the thing that you need in combat. The doctors actually have to be with the troops. The doctors that operate the battalion aid stations, the doctors that see these wounded first should be with the troops long enough to know them and be accepted by them as being one of them. I do think the numbers should be held to a reasonable minimum."*****

"I do favor the immediate formation of a permanent joint board.

Brigadier General Martin: "At the Chief of Staff level?"

Colonel Westervelt: "Yes, sir. I am not in position to recommend what powers and authority should be given that board, but I would certainly think they should be pretty wide. And I do think the planning for future operations in all fields, including procurement, should be a function of this board at the chief-of-staff level."*****

RECORDED

L. R. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON B. WILLGUTTS (MC) USN
4 May 1948.

***** J. * The next item is the general relationship with other branches of
The Armed Services relative to medical planning and requirement.

There was a feeling that the medical services in various echelons were
at a disadvantage during the war in not having sufficient information concerning
future plans. It led to uncertainty and confusion and a waste of personnel and
material. It refers to other branches of the Naval Service and to other branches
of the Armed Forces. It covers the whole subject.

REAR ADMIRAL WILLGUTTS: An officer must know the score if he is going
to deliver his best service. May I relate an incident I had out at San Diego.

Some of the finest doctors I have ever known came from Texas as a unit.
They dropped everything and came in as good sports. One doctor, a very excellent
cardiologist from Houston stayed at the hospital for two years. Then he came in
to see me and said - I've got to get to sea; I can't spend the war at San Diego.
I said: "You're doing a grand job; I can't spare you". He said: "I can't go
home if I don't go to sea?".

That very same day a request came in and I got him transferred to a hos-
pital ship. He was delighted. Four months later transportation was arranged on
this hospital ship from Guam and of all people there was this cardiologist aboard.
He greeted me cordially, of course, being an old shipmate, and yet I could detect
an unhappiness and discontentment. I said: "What's the matter - don't you like
the skipper?" And he said, "Oh, the skipper is fine". And I said: "Well, how
about this new medical officer, is he ridding you a little bit?". And he said,
"No, he's fine". I said: "I know you're unhappy, and I'm sure you're not scared."
And I said: "Well, don't you know where we're going?". That was it.

We doctors on this staff are good men; we are not kids. We are matured.
We know we are going to go to a rendezvous but we don't know where. We hear rumors
from here and there that something is going on. We don't know what it is. They
were let down. They were just fed up.

Here I came aboard thinking I'd get the news, and they didn't know. Some
of them had no idea that they were going to Okinawa. They were in the advance zone
and yet were denied the strategy of the campaign. I took that up with Spruance
and he was amazed and said he didn't realize it, that he had never thought of that.

Our staff and our doctors must know the score. We should be in on all
planning; and as doctors and officers we certainly are capable of maintaining as
tight lips as any other officer.

REAR ADMIRAL ANDERSON: The Subcommittee has discussed some organization
which would in an authoritative way coordinate medical activities of the three med-
ical services. We have discussed a joint medical board on a high level, say the
Joint Chiefs of Staff level, which would be in a position to obtain or to receive
plans of future operations and, with due regard to the secrecy of the plans, would
transmit them to the headquarters of the three medical services. They would be in
a position to, for one detail, regulate the distribution of hospitals so the hos-
pital services would not be needlessly duplicated.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USE
4 May 1948. J CONTINUED:

Do you have any suggestions to offer about who should compose such a board and what their additional functions may be?

REAR ADMIRAL WILLCUTTS: Medical planning, to my mind, goes and stems from the top echelons. We should be in on all present strategical and tactical planning. Above that I think, keeping in mind civil defense, medicine should have representation at the highest level, and that would be the National Security Council. I have heard they have recommended that we should have medical representation on the National Security Resources Board. But what or rather why we should be denied the other, which is the right hand part. I think we should have representation, certainly, with Central intelligence. If we are going to war, good medicine must be developed and must definitely be the first thought this time. So not only for military but for civil defense we should have planning.

The forces should be represented, in my mind, on the National Security Council and also as a component of the National Security Resources Board, and then on down through to the Chiefs of Staff, the Munitions Board, and so on. They should have medical components, and they should also be out in the field. In fact, I think the Marines do that better.

I recall in World War I we knew what was going on. That was closer. I think you people in the Army have better knowledge than we in the Navy. You are a closer organization, perhaps. We in the Navy at times are isolated on ships and we don't know where we are going or where we came from or what the score is. Definitely medical planning should stem from the top and be at the top.*****


L.K. POEL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL CORNWELL, MC, USA, 30 APRIL 1948

***** J. "General relationships with other branches of the Armed Services relative to medical planning and requirements". There was a distinct personnel conflict on the reserve basis which gave much dissatisfaction. Prior to the last war, medical men coming into the Army could only come in as lieutenants, while the Navy was offering much higher commissions to specialists. I had a friend of mine who was an expert and just before the war he asked if he should join the reserve corps as a lieutenant. He said, "The Navy offers me a lieutenant commander. What shall I do? I would rather go in the Army.". I said, "Wait. When they need you they will offer you a majority if we are at war". But he had to wait until we were at war.

And that's just what they do. I think many men could be secured for the services if - and I think that has been changed at present by the new law, but that was one of the difficulties we had earlier.

The joint supply program is considered basically excellent and might well be extended. The same should apply to food. Incidentally, it's unfortunate that there are quite a few areas in that new supply catalog that made it a little complex, and during this period of consolidation we are securing many standard items, items of supply, on the open market. We can't get them otherwise. On photographic supplies there has been a terrible mix-up. We are getting everything from the Signal Corps. Then we began to get certain items from the Signal Corps and some of the other items fully from the AirCorps. We have just about gotten that lined up so that we know our channels of supply and I believe its going to be changed back to the Signal Corps again. In the meantime, we are without some items to do our clinical photography. We are buying right now standard items on the outside. Whether it's due to source shortage, shortage of manufacture, I don't know, but the joint supply program has been I think basically a sound idea but it apparently has broken down a little bit in its actual function.

I think this relationship between all branches is a high-schelon problem. It should be approached with caution to avoid conflict at all levels. Basically, it's sound and should ultimately be used; but we know that it's just human nature to resent having your outfit called something else.*****


L.E. FOEHL, COLONEL, MC

RESTRICTED

RESTRICTED

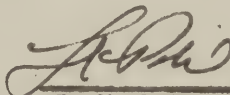
TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA
13 May 1948)

MAJOR GENERAL KENNER: ***"In general medical department organization must recognize other elements and commitments of medical service besides the purely professional. Specialization has been overemphasized at the expense of the medical field service.

There should be medical representation at the highest level -- at the Joint Staff and Joint Chiefs of Staff level -- for the reason that differences will arise that must be reconciled by the authority vested in a group, or individual, who speaks for the Secretary of National Defense. I do not believe that the line officer, the general staff officer, can have a proper appreciation of medical problems, that he is not in possession of adequate knowledge, either through training or otherwise, that will permit him to make the proper decision. *****

Going to the next question -- general relations with other branches of the Armed Services relative to medical planning and requirement -- there should be staff representation at all echelons. That's all I have to say on that.*****

*** I don't know about the advisability of creating a separate hospital construction section in the Engineer Corps, because it might in some circumstances deprive tactical units of engineer support.*****



L. K. Fohl, Colonel, MC

RESTRICTED

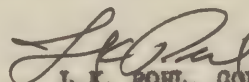
RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH BRIGADIER GENERAL JOSEPH E. EASTON,
MC, USA, (RETIRED) ON 3 May 1948.

***** J. " General relationships with other branches of the Armed Services relative to medical planning and requirements." They should have a part in every school, every echelon from top to bottom.

BRIGADIER GENERAL MARTIN * OFF THE RECORD.

BRIGADIER GENERAL EASTON: The present highest level of coordination, I believe, is the Joint Chiefs of Staff. I believe that one section of that should be called a Medical Section and should be composed of representatives of all the Armed Services of the Medical Department business.*****


L.K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

D-1k. Factors contributing to alleged overlapping of medical functions among the Armed Forces.

I. DISCUSSION

1. There is variation in opinion expressed relative to the degree and form of overlapping of medical functions as are reported having been observed during and following World War II. Some are most vehement in their denunciation of various medical duplications and which they believe could and should have been prevented. Others advocate continuing a certain amount of what appears to be duplication, because of the reserve coverage provided and reciprocal available help to one another's facilities in event of emergencies.

2. In no field of comment is there perhaps more necessity for consideration of the competency of the observer and the facts and knowledge upon which his statements are based than with this subject, for it extends into all utilization of medical resources, and it must be realized each Force requires its adequate medical support to perform its mission whether provided by single agency or by multiple similar agencies.

3. The medical support must follow the people it was created to serve and in a broad sense apparent duplication results when each Force, with a different mission and using different units and weapons exerts a converging effort toward common goals. Thus, the hind sight statements made in some instances with malicious and fault finding intent relative to overlapping should be considered for what they are worth and weighed against the planning and operational requirement situations which existed at the time.

4. The major efforts now being conducted by other Subcommittees dealing with the problems of medical personnel procurement and distribution, medical materiel procurement and distribution, in hospitalization procedures and in military medical research is believed directed toward determining respective Force needs therefor, coordination and unified effort where possible, but all such action tempered by the understanding and guiding reason for the existences of each of the military forces and which is "to prepare in Peace for War". Agencies as are consolidated during peacetime for economical reasons must be adequately organized and planned for expansion to serve the needs of each Force concerned during wartime.

5. It is believed there are certain medical functions requiring service identification but which may be coordinated by an interdepartmental Medical Agency and finally that there are some which may be operated jointly or unified and with policy control by an interdepartmental Medical Agency, recommendation for which has already been made.

6. Functions considered requiring complete service identification may well be; Troop, Tactical unit and aboardship Medical Service; Station and base level hospitalization; small scale and tactical evacuation of patients; tactical medical training; sanitation; nutrition control; medical inspection; organization for Major Force Medical Service; determination of Major Force Medical Service requirements; and personnel classification, career control and assignments.

RESTRICTED

RESTRICTED

7. Functions requiring service identification but which are believed quite adaptable to coordination of effort by an Interdepartmental Agency may well be: Medical budgeting; establishment of physical standards; and medical aspects of appointment, disposition and separation; specialized medical research; medical reserve program; large scale evacuation of patients; definitive hospitalization; hospital design and construction; basic medical training; specialized professional training; employment of professional consultants; medical aspects of chemical and biological warfare; and war, mobilization and emergency medical planning.

8. Functions for joint operation may well be: Medical material procurement, depot operation and supply distribution; personnel procurement; non-specialized and service-common medical research; institute of pathology; certain general training agencies; medical libraries; medical intelligence and nutrition laboratory.

II. CONCLUSIONS

1. There is no existent law providing for unification or merger of the Armed Force Medical Departments. It is believed that each Major Force must be intrinsically provided a reasonably complete Medical Service at the operational level as exemplifying the intent of Congress in policy declaration prefacing the National Security Act of 1947. In brief, it provides essentially three military departments....with their assigned combat and service components.....for their authoritative coordination and unified direction....but not to merge them.

2. That contrary to first general impressions that overlapping of medical functions and facilities can be avoided by some simple method of control, full investigation of the details where the supposed overlapping exists, reveals that the necessity for continuation of present methods of Departmental control exists in most cases.

III. RECOMMENDATIONS

1. That considerations and recommendations of existing Subcommittee projects many of which are now operating with concepts of peacetime needs only, be analyzed fully as to their potential adaptation in the event of another National Emergency. That any peacetime unification and consolidation of activities of the Medical Departments for the Armed Forces as are implemented for existent economical reasons, be approved or accomplished only after full certainty and agreement is established that an adequate Force identified Medical Department may still evolve and be capable of rendering necessary and adequate complete Medical service to the arm it serves.

2. That "unified and coordinated effort" be adopted as the guiding principle of the respective Medical Departments of the Armed Forces, but that any further stressing of unification and one Medical Service objective be tempered in order that continuance of the historically demonstrated efficiency and accomplishments of the Army Medical, the Navy Medical and potentially the Air Medical Departments may be insured, and their complete absorption of identity eventually in a civilian controlled agency, can be prevented.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M. J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

***** "(k) Factors contributing to alleged overlapping of medical functions among the Armed Forces.

My experience in all of these matters is confined to the Pacific area. Certainly in the early days of the Pacific war we needed everything that we could get in this respect. It was inevitable therefore that an abundance and perhaps a super abundance of hospital facilities would eventually become available. This was in direct relationship to our overwhelming production. In my opinion too much is infinitely better than not enough. Perhaps in the future a more realistic appraisal and estimate of our needs may be employed so that instead of both army and navy establishments being located in the same area, either naval or army facilities would be what was most desirable. This is a decision however which must be made when the needs of an area can be adequately determined. Army medical facilities were always available to our needs and by the same token, we took good care of the sick and wounded of the army. No distinction was made here." *****

~~RECORDED~~

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTEDTRUE COPY EXTRACT (Letter, Colonel Hervey B. Porter, MC, USA, 23 April 1948)

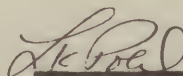
***** Background. Departure for overseas was made early in May 1942, spending approximately less than one month in Cairo, Egypt, and arrived CBI Theatre early June. The theatre commander had assumed jurisdiction over all armed services. The Air Force was an operating unit. The various services were present in skeleton or absent. Evacuation of a portion of General Stillwell's personnel to the ZI, as well as General Doolittle's raiders were necessary. Medical supplies were present only at Karachi, and dependence was placed on the British for hospitalization at all other points. In the late summer of 1942 command of the U. S. AF CBI was placed in the hands of the most brilliant individual I have ever had the pleasure of knowing. A man of breadth of vision, energy, determination, and fairness, without parallel in my opinion. Despite his utmost backing, medical services to the air force personnel suffered for the following reasons:

"a. Divided responsibility between Theatre, Service of Supply and Air Forces.

"(1) Too much time was spent in arguing jurisdictional responsibility and resources available to get medical care promptly to the troops. *****

***** " That strong central control of the available medical facilities in that theatre was imperative; that coordination between individuals responsible only for parts of the entire medical program even on the most friendly basis, resulted in tremendous loss of time and effort. *****

***** "Constant bickering occurred, unfortunately, between the three forces represented, all over trivia, but I am happy to say that at no time were the Air Force medical needs imperatively urgent from enemy action or outbreak of disease, that the Surgeon of the SOS did not come, or I go to him, and work for the correction of the emergencies in absolute harmony and singleness of purpose. After the emergency was passed, again the question of trivia would arise mainly over the control and utilization of medical supplies and continue until the next emergency. Our allies, the British, were always of unestimable help, and willingly divided their slender medical supplies right down the line. It is felt that in all that the sick rate for the U. S. Air Force's, CBI, was very low comparatively, and the care of battle casualties, at least through October 1943 (the date of my return) were very well handled with the slender resources of professional men and supplies available." *****

RESTRICTED


 L. K. Pohl, Colonel, MC

RESTRICTED

TRUE EXTRACT COPY: (Letter from Colonel Richard T. Arnest, Ret.
dated 19 April 1948)

***** "k. There was definite overlapping of medical functions in the Headquarter establishment, supply, hospitalization and etc. These were unavoidable under the organization and will I fear, continue to overlap unless very strong pressure is brought to bring about closer coordination of the three branches -- each is jealous of its prerogatives. *****

RECORDED

L.K. Pohl
L. K. Pohl
Colonel, U. S. Army

TRUE COPY EXTRACT (Ltr Rear Adm F.L. Conklin, (MC) USN, dtd 27 Apr 48)

***** K. "Overlapping of medical functions of the Armed Forces could be prevented by a Joint Armed Forces Board in Washington.*****

RECORDED
L.K. POHL, Colonel, MC

TRUE COPY EXTRACT (Ltr Capt. M.S. Mathis (MC) USN, dtd 6 May 48)

***** K. "The Army and Navy both operated Medical Supply Depots in Hawaii. This duplication in function operated to advantage of both services. It was a frequent occurrence for one service to furnish supplies and equipment to the other when either was short or out of materials."***

L.K. Pohl
L.K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 22 April 1948)

***** "(k) Factors contributing to alleged overlapping of medical functions among the Armed Forces.—From my point of view there was no alleged overlapping. There was overlapping. Again and again there were instances where there was a naval supply depot and an army supply depot in the same area. Again and again there were hospitals run by the Air Force, by the Service Force and by the Navy in the same area with no correlation between the three. I think any of us in civilian medicine who had any extensive service in the army could cite many examples of this overlapping and, therefore, it would appear in your memorandum where it is marked as "alleged" overlapping is dodging the issue."*****

RECORDER

L. K. Pohl
L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter Capt. E.P. Kunkel (MC) USN, dtd 21 Apr 48)

*****K. "I believe that Army, Navy and Army Air Force medical officers should at all times maintain their present identity. However, there certainly should be no overlapping of hospital care for the armed forces. Hospitals should be staffed, if Navy, with naval medical officers, and Army hospitals with Army medical officers. Nevertheless, all armed forces personnel, including dependents of same, should be admitted in like manner, whether Army or Navy, and at the same per diem. This would necessitate a uniform system of personnel accounting, administration, nomenclature, etc. Hospitals of the armed forces could be designated as Armed Forces Hospital No. 1, etc., vice Army, Navy or Air Force." *****

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr Alfred W. Eyer, Captain (MC), USA, 17 April 1948)

***** (k) Factors contributing to alleged overlapping of medical functions among the Armed Forces.

Factors contributing to overlapping of medical functions arise from the following:

1. Lack of joint planning.
2. Differing service field and zone of interior administrative procedures.
3. Maintenance of different types of records (patient-personnel) and type reports required.
4. Utilization of specialist personnel in the zone of communication where each service attempts to meet its own requirements.
5. Maintenance of duplicate supply systems in both zone of the interior and the communication zone.*****

RECORDER

L. K. Pohl
L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee, dated 18 April 1948)

***** (k) Factors contributing to alleged overlapping of medical functions among the Armed Forces.

"Principal factor is that there are three services instead of one as there should be. Rules against interchangeability of personnel, of patients and equipment all contribute but would be eliminated if the basic intention of Congress -- unification -- were achieved." *****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr James E. Hix, Lt Col., MC (Resigned) 11 April 1948)

*****My reaction is probably prejudiced. Obviously, from the point-of-view of the tax-payer. One medical service taking care of the Navy, Army and Air Force is all that can be justified. But it would be difficult to convince certain people of that, or that because of the role of the Air in future protection of this country, that Gen Grow should be the policy maker, and not the ground or water."*****

RECORDER

L. K. Pohl
L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Brig. Gen. Robert C. McDonald, MC, USA (Ret.), dated 15 April 1948)

***** (k) Factors contributing to alleged overlapping of medical functions.

"(1) Comment: Overlapping occurs in procurement of medical personnel and equipment, lack of standardization in supplies, and failure to coordinate the requirements and operation of medical facilities, in areas occupied by more than one of the Armed Forces." *****

RECORDER

L. K. Pohl
L. K. Pohl, Colonel, MC

TRUE EXTRACT COPY (Ltr Brig Gen Guy B. Denit, MC, Surgeon, dtd 13 Apr 48)

***** K. "In past war there was no one in authority to say to anyone of the three services that so and so would be done."*****

L. K. Pohl
L. K. POHL, Col. MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. R. Urban (MC) USN
dated 28 April 1948)

***** "(k) Factors contributing to alleged overlapping of medical functions among the Armed Forces.

"(1) Lack of close relationship with other services or commands contributed to overlapping." *****

RECORDED

L. K. Pohl
L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus (MC) USN
dated 27 April 1948)

***** "(k) It would be my feeling that in general, alleged overlapping of medical functions among the Armed Forces during World War II were more imaginary than real. Each service had its respective mission to carry out and in so doing, functioned to full capacity without undue duplication of effort. There were undoubtedly specific instances of overlapping of some medical functions but through joint cooperation and get-together, the Medical Departments of the two services often assisted each other in precluding duplication of facilities or function. An example of eliminating overlapping of function can be referred to in connection with material procurement. To begin with the services were in competition with each other in the procurement of certain material items but it is believed that this situation no longer exists since the Joint Procurement Agency was established." *****

RECORDED

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

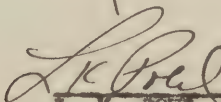
RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C. B. Camerer (MC), U.S.N.,
Retired dated 21 April 1948)

**** "(k) Generally under "(j)". Personally no great amount of embarrassment from this source, aside from diverse equipment, etc., was observed. Laboratory work could well be better correlated and simplified among the different branches of the Services by closer cooperation and the application of the same general principles as submitted under "(j)".*****

TRUE COPY EXTRACT (Letter, T. F. Cooper, USN, dated 19 April 1948)

***** "The Army Navy joint catalog and the joint purchasing agency is a great stride forward insofar as medical material is concerned, and should do much to conserve manpower and achieve the optimum utilization of available manufacturing facilities. Further, the possibility of tying up certain facilities for use by a single service to the exclusion of all others is precluded. Standardization of specifications and interchangeability of items is invaluable. Those charged with material requirements planning should have access to high level information in order to plan wisely. During the last war insufficient information was available to responsible individuals, who were forced to rely too much on the 'crystal ball'. Under the present administrative set-up, relationship with other branches of the armed services will be improved with respect to medical planning and requirements. While inter-service relations during the war were always cordial, they were not always effective. There was, however, a considerable degree of cooperation between Army and Navy medical material logistics agencies in New York and Brooklyn, each helping the other when the need arose. In the field of personnel and material planning, much can be accomplished by close coordination, but it is my firm opinion that naval and military hospitals should not as a rule be combined. When a small unit of one service is in the vicinity of a hospital of another service, medical service should be rendered to the smaller group as required. This, of course, is presently done and has been done for many years. Overlapping of medical functions is not nearly as great as would appear on casual examination." *****



L. K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain H. D. Templeton, MC, USN
dated 23 April 1948)

***** "(I) FACTORS CONTRIBUTING TO ALLEGED OVERLAPPING OF MEDICAL
FUNCTIONS AMONG THE ARMED FORCES.

There were no occasions that came to my attention in which there was
overlapping of medical functions among the armed forces." *****

TRUE COPY EXTRACT (Letter, Colonel John A. Rogers, MC, USA (Ret.)
dated 19 April 1948)

***** "K. Factors contributing to alleged overlapping of medical
functions among the Armed Forces. It is believed that medical units
could be developed which are suitable for the care of infantry soldiers,
sailors and air corps personnel. They are all human beings and much
duplication could be saved by recognition of this fact. The desire
of the Air Forces to have special hospitals is a notable example of
this duplication." *****

RECORDER

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Robert M. Gillett (MC) USN
dated 15 April 1948)

***** "The over-lapping of medical functions among Armed Forces
is an advantage under combat conditions if Task Force or Area Com-
manders are permitted free utilization of manpower and equipment."

RECORDED
L. K. Pohl

L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Dr. A. R. Shands, Jr., dated 20 April 1948)

***** "There was a great deal of over-lapping of medical func-
tions in the armed forces. The duplication of facilities and per-
sonnel in many communities was very evident. Coordination of the
armed forces medical service will certainly prevent the recurrence
of this. The chief circumstance which lead to disaffection of
medical personnel was the lack of proper assignment and the failure
to obtain promotions when the personnel thought they were due. I
personally believe that all rank should be abolished in the military
medical services. A doctor's prestige on a post even though he
might be an excellent physician was not what it should be if he did
not have comparative rank to non-medical personnel. This had a
tendency to lead to lack of respect on the part of the layman for
the doctor." *****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY (Extract from Ltr W. H. Michael, Rear Admiral (MC), USN Retired)

RESTRICTED

**** "My personal relations with the Army relative to planning and requirements while in the southwest pacific were excellent. The Army Medical Department kept me posted as to their moves so that work could be coordinated.

"As a result of this cooperation described in (J) above, I do not recall a serious case of overlapping of medical functions in my service in the Southwest Pacific. On the contrary, the Army Medical Department frequently was able to and willingly did help out the 7th Fleet when for any reason there were discrepancies in Navy Medical Supply or personnel. The Navy was frequently able to help the Army in the same way." ****

RECORDED

L. K. Pohl
L. K. POHL
Colonel, MC

TRUE COPY EXTRACT (Letter, Captain J. H. Robbins, (MC) USN
dated 26 April 1948)

***** "Reduplication of Medical Department Activities: At practically every Base in the South Pacific area there was reduplication of all medical facilities, hospitals, supply, depots, etc., and there was only a few times during their existence that any one of the hospitals were filled to capacity. It is recommended that in the future one hospital of sufficient capacity be erected and that it be staffed by both members of the Army and Navy Medical Corps and it's designation be made as a U. S. Hospital and it's commander be designated by the area Commander from available personnel. It is further recommended that only one Supply Depot serving all forces be set up in an area." *****

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract from Ltr Col Harry G Armstrong, MC, 16 April 1948)

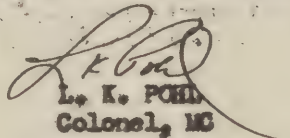
*** "k. Factors contributing to Alleged Overlapping of Medical Functions
Among the Armed Forces.

(1) Defects:

- (a) Unwillingness of service personnel to accept hospitalisation from another branch.
- (b) Unwillingness of branches to provide hospitalisation for other services.
- (c) Empire building.
- (d) Adherence to tradition.

(2) Remedies:

- (a) Mixed staffs at all hospitals where various services are represented in sufficient strength to warrant this; organisation numerically strongest in area should operate main hospital facility." ****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Dr. Howard A. Rusk to Secretary for Air dated 27 January 1948)


***** "There are at present in the Air Force, 190 regular medical officers and approximately 50 category I reserves. The remainder of the complement of doctors is made up of ASTP students who will finish their tour of duty within the next few months. The minimum requirement of doctors in the Air Force is approximately 800. Although I do not have the figures, I understand that the other branches of service are in a more or less similar position. The procurement problem is critical.

"To illustrate how important is the pride of belonging, a recent survey in class A medical schools was circulated to former Air Force pilots now in medical schools. 67.3% were interested in a service career and 72.5% of those would prefer service with the Air Force provided a medical career in the Air Force could be assured. If such an appeal were made to all former members of the Air Force in medical school, it seems logical that a considerable number of excellent career physicians could be obtained.

"I feel as you do that the over-all problem should be our first consideration. I am not convinced that a single medical service with its attendant overhead in housekeeping, administration, communication, supply, etc., would provide an economy in personnel. I feel in light of the foregoing discussion that a medical service coordinated under an armed forces medical council, responsible to the Secretary of Defense, is the most logical solution.

"It would seem appropriate to request the Secretary of Defense to issue a directive establishing under the command of the Chief of Staff of the Air Force a medical, health and sanitary service capable of supporting the Air Force in all phases and situations of its assigned mission. Furthermore, that the commanding officer of the Air Force medical, health and sanitary service be the medical advisor to the Secretary of the Department of the Air Force and the Chief of Staff of the Air Force. This would assure the Air Force of command responsibility over selection, medical evaluation and separation of its personnel." *****

RESTRICTED


L. K. Pohl, Colonel, MC

RESTRICTED

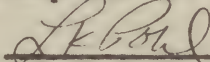
TRUE COPY EXTRACT (Letter from Rear Admiral A. H. Dearing (MC), USN
dated 26 April 1948)

***** (k) Factors contributing to alleged overlapping of medical functions among the Armed Forces.

The first factor which contributed to actual overlapping of medical functions was the supply of medical materiel. Because of the differences in requirements of Army and Navy; the fact that there were different supply catalogs and the difference in the organization of the logistic services within the Medical Departments, it was necessary to establish both Army and Navy Medical Supply Depots and storehouses. To the laymen this appeared inexcusable but to have attempted unification of medical supply systems within the combat and communication zone at the time when all efforts were directed towards pressing an offensive against the enemy might have been disastrous.

The erection of Navy and Army hospitals within several miles of each other on the same island base has been criticized both by medical personnel and the laity in the scientific and public press. The number of hospital beds required at each island base were allocated to the two services by the Commander of the Area (medical officer) in accordance with the anticipated needs. The allocation was divided between the two services in accordance with the number of personnel of each service who were engaged or expected to be engaged in combat operations. It must be born in mind that these island bases were not large and that the area in which hospitals might be established was necessarily restricted. It is agreed that a hospital of over 1500 beds is unwieldy and undesirable, and for this reason it was considered better to have two hospitals of 1500 to 2000 beds each than to have one hospital with three or four thousand beds.

It has been alleged in the press that the Army and Navy both established large hospitals in the New Hebrides--Solomons areas which stood partially emptied for many months of the year. It is submitted that time is required in the planning, ordering and establishment of hospitals and this must be done prior to the beginning of an offensive which may send to these hospitals large numbers of wounded. The writer is aware of the fact that probably all of the hospital beds established in the New Hebrides and Solomon areas were not used but, at the time that they were erected, the plans of the Commander of the area called for a major all-out attack on well fortified and strongly manned Japanese bases. These plans were changed after the hospitals had been erected but, had the plans been carried out as first projected, every hospital bed which had been placed in this area would have been required. The same individuals who now criticize the fact that these hospitals were not used would have been the loudest in their denunciation of the services had there been large numbers of wounded with no hospitals to receive them.*****



L. K. Pohl, Colonel, MC

RESTRICTED

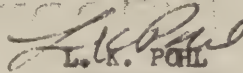
RESTRICTED

Extract of Statements made by Brig Gen Robert C. McDonald, MC, USA (Retired),
21 April 1948, before the Subcommittee on the Employment of Military Medical
Resources.

****"The next subject. "Factors contributing to alleged overlapping of medical
functions."

"Overlapping occurs in procurement of medical personnel and equipment, lack
of standardization in supplies, and failure to coordinate the requirements and
operation of medical facilities, in areas occupied by more than one of the
Armed Forces."

I am sure that we can and will cooperate and coordinate our medical services
in the future. I think that the merger which has been brought about certainly
is in the interest of efficiency of the medical service, and that there
will be economy in it and perhaps a higher standard of care and treatment."****


L.K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY:

(Extract of statements made by Colonel Thomas J. Hartford, MC, USA on 23 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

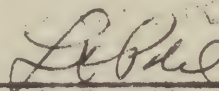
***** "k. In the ETO the Army made up the much larger complement, and I don't think that there was a great deal of overlapping of medical functions among the armed forces. We were criticized, for example, and have been since the war, in one case because the Navy had one fixed hospital in England. Said our planning was poor. Well, actually, that was a hospital that we took from the British. It would have been staffed in any event, and Navy were perfectly honest in stating that they wanted that hospital because it would be a naval hospital and show the flag, and that was all there was to it, and I think it was perfectly justified.

We hospitalized each others cases. We kept the same records on them and took care of them and generally worked very well. I don't think there was much overlapping. We didn't have the same problem perhaps they had in the Pacific in that respect.

Relative to all field hospitalization organization and equipment being identical for all services, I think that would be desirable, and our services are together. We have had some meetings down at Camp Lejeune in North Carolina in which they are trying to work out just that thing. I see no reason why a Marine field hospital or surgical hospital should be any different than an Army hospital. I think they should be the same.

"As a ground activity would you recommend in the interest of economy that all field hospitalization in the armed forces be furnished by the ground forces?"

If they had started out planning on that initially, that perhaps would have worked, but under the circumstances if they had a field hospital for their support and didn't mean taking the patients past some Army installation, it's all right with me.***



L. K. Fohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE MEDITERRANEAN THEATER
HISTORICAL SECTION - AFTAS

***** K. "In spite of attempts to simplify channels, however, much duplication of effort remained. A directive prepared for the Surgeon, Army Air Forces, Mediterranean Theater of Operations, had to be coordinated with Headquarters, Army Air Forces Service Command, as well as with Headquarters, Army Air Forces, Mediterranean Theater of Operations, and in some instances with Headquarters, North African Theater of Operations. Upon its return, if approved, an appropriate directive was prepared for major echelon Air Force commands, one of which was the Army Air Forces Service Command itself, and for subordinate units attached or assigned to the Army Air Forces Service Command.*****

RECEIVED
L.R. PO L, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** "(K) I think one great possibility of overlapping of medical functions would come in the sphere of hospitalization.

"1. I believe a beginning has been made in eliminating overlapping functions by the joint supply. In the field of hospitalization and evacuation. No objections to joint use. No objections but overall plans should be made before any such scheme is set in motion.

"2. I believe they should. I think it would be more economical from the standpoint of procurement. I believe it could. I believe that each should keep its own basic installations for morale of patients.

"3. I believe it is. The administrative difficulties are the main factors. Against combined use. Yes.

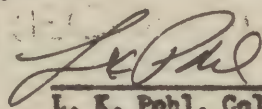
"4. I believe that a truly unified medical service is not exactly the proper thing because the Army, Navy and Air Force have different problems and missions. There has to be some difference between the services because I don't believe it would be possible to organize all units to satisfy the needs of all three.

"6. I believe a single list could be used for all the services as an economy measure but I do not see any need for a constant ---- of civilian consultants because in due course of time I believe the services will have their own specialists.

"7. Yes. I think it could be coordinated. The problems of the two services are almost identical.

"8. I believe that a Procurement Board on the Defense level would be the only solution to that problem.

"9. I don't believe it would. I believe you should have a Surgeon General of each even in a unified service."*****



L. K. Pohl, Colonel, MC

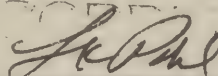
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain O. B. Morrison, Jr., MC, USN
dated 23 April 1948)

***** "k. Factors contributing to alleged overlapping of
medical functions among the armed forces.

There should be clear-cut, concise directives from
higher authority as to the duties of each component. Meetings
of the representatives of each branch will engender confidence
and mutual respect, and will do much to prevent overlapping of
functions."*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Arthur B. Welsh, MC, USA
dated 19 April 1948)

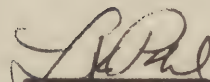
***** "k. There was definite overlapping in the procurement of Medical Department personnel as well as in the field of supply.

"There was overlapping in the hospitalization of the zone of interior as well as in certain overseas theaters where joint operations occurred on a large scale.

"There was overlapping in medical laboratories and in research.

"There was less overlapping in evacuation than in any other field.

"The major factor responsible for overlapping and not alleged overlapping was so-called departmental allegiance sometimes bordering on jealousy. The other major factor was the existing command structure within the Army and perhaps within the Navy; of the latter I have no knowledge." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

***** "k. The principal reason for overlapping of
medical functions among the Armed Forces was lack of mutual
recognition, resulting in poor coordination and cooperation,
also the lack of authority to direct procedures." *****



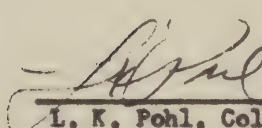
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel F. A. Blesse, MC, USA dated 19 April 1948)

***** "11. Factors contributing to alleged overlapping of medical functions among the Armed Forces. Discussion: The factors contributing to alleged overlapping of medical functions among the Armed Forces are really inevitable in view of the existing organization for national defense. With two separate medical services serving the Armed Forces it goes without saying that overlapping of medical functions in many instances are the natural result of dual organizations each working towards its own goal. The lack of unified control and supervision at the highest level causes such overlapping. Closer cooperation at all echelons of command would prevent a considerable amount of overlapping but until such time as a system of overall control and supervision is instituted overlapping is to be expected and will be the rule rather than the exception." *****



L. K. Pohl, Colonel, MC

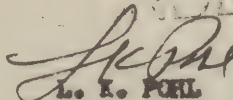
RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr M. C. Stayer, Major General, U. S. Army, Retired, 11 Apr 48)

***** (k) Factors contributing to alleged overlapping of medical functions among the Armed Forces.

1. The desire to build up an empire and obtain credit for the service to which they belonged.
2. Lack of coordinated planning with the various groups as to the requirements in the areas where either fighting or near-fighting was to take place.
3. Inability of commanding officers to coordinate their ideas.
4. Men in ^{high} gain places with poor personality, no imagination, no training in organization, and little ability to get things done.
5. The Theatre Surgeons had little or no contact with the policy-making group of the medical service.*****

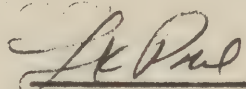

L. K. FORL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert K. Simpson, USA (Ret.)
dated 1 May 1948)

***** "(k) Factors contributing to the alleged overlapping of medical functions of the Armed Forces. This has been mentioned to some extent already. As has been said, it is believed that general hospitals of specialized nature within the zone of the interior could serve all components of the Armed Forces, and the same may be true of general hospitals within the combat zone. However, each component of the Armed Forces should have its medical Dept. and could supply personnel to staff such hospitals."*****




L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Bascom L. Wilson, Colonel, MC, Air Forces, 21 April 1948)

****Reference par 3(k) "Factors contributing to alleged overlapping of medical functions among the Armed Forces," many instances of overlapping of medical functions were noted, most noted of which was the duplication of Ground Force and Air Force Hospitals in the same area, often contiguous areas, a good example of which was El Paso, Texas, where there existed the Air Force Station Hospital at Biggs Field; it certainly couldn't have been in the interest of economy either from a monetary point of view or that of economy of medical personnel, and it would seem both logical and economical, financially and otherwise, for one hospital, be it Army, Air Force or Navy, to serve any given area where geographically suitably located."****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

***** "(K) 1. In my opinion, yes. I am not qualified to pass final judgment on it. I think that the joint supply program is certainly a definite step in the right direction. In administrative procedures, particularly in the care of patients, in handling their records, it's definitely indicated; also in standardisation of forms for physical examination and others of that nature.

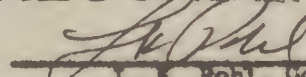
"Objections to joint use of hospital facilities in ZI, in my opinion, are minor. I think they involve an understanding of joint administration and staffing, which can only be worked out with experience. I think that we are getting into the field of the Hawley Committee's setup. I am not competent to pass judgment on that.

"Whether hospital facilities are used jointly or operated jointly is something which in my opinion represents two different things. A hospital run and staffed, for example, by Navy personnel can and has handled personnel from all over the services. I have never seen a hospital which was run by a representative of one service and staffed by members of all the military services. I guess it can be done all right. With our Army, Navy, and Air systems as we have them now set up, I should certainly think it would be easier for the moment at least to operate our hospitals under one head and then permit patients of other services to come in, rather than try to try joint staffing, although I think we are going to come to that before we get through.

"Standardisation in field-type hospitalization would certainly tend to efficiency, to economy in procurement, and to ready interchanging of the unit from one force or service to another. This in my opinion represents a distinct advantage.

"I feel that any ground activity should be furnished by and part of the ground forces. The ground forces are naturally interested in their own medical service, and I think that they should be the prime factor at least in developing the tables and equipment lists for these hospitals.

"I can't answer this on standardisation and fixed hospitals in the ZI. In the ZI peace and war, I am not in position to answer whether we can standardise hospitals, or not. I would say partly so from a standpoint of expense and planning the layout which, I understand, is very expensive in planning the hospital buildings and what not, and if we could have a more or less standard layout subject to local modification, I certainly think it would be more economical."

RECORDER


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview
with Subcommittee on the Employment of Military Medical Resources

"As far as staffing and equipping these hospitals, I think that would depend upon to what extent the surgeon general wanted to specialize activities in the several hospitals.

"(K) 3. This is personal, too, but I am going to answer it. I don't think that the administrative difficulties of operating joint service hospital facilities represent the paramount objection for combined use. I think the chief objection is habit; maybe the selfish interest of the individual who wants to work with the people that he is accustomed to working with, or who feels for some reason or other that his particular service does things more to his liking than the other service. In short, I think it's a human feeling that requires education before we can come to successful joint staffing and operating of a hospital facility.

"I think the idea is so new to service personnel who ever since they have come into the services have felt that their service was just something apart, and what we need is a realization that we have much more in common than many are willing to admit, and that there is no practical or serious objection to joint staffing and operation. I don't think any of these objections are sufficiently serious to discourage trial, and I am very optimistic about the results if they are given a fair trial.

"The answer to the latter part of question 3, certainly a unified system of administration, including forms and laws, would very definitely facilitate the joint staffing and operating of medical units. As a matter of fact, it would almost make them so simple that they wouldn't be joint any more.

"(K) 4. As far as 4 is concerned, mandatory coordination is, I think, the only way that a real coordination of these medical services can be initiated. It will require mandatory coordination to set up a system which will eliminate many of these overlapping or alleged overlapping functions. A direction by a medical head in the form of a medical section or staff agency on the level of a Secretary of Defense would certainly break the ice in starting the coordination of these services and bringing about what in my opinion is a true merger of the medical means of the armed forces.

"(K) 6. Answer to No. 6. I should think that a single list of consultants should be established as an economy measure. I am not familiar with how these consultants are being handled now, but I do know there are several lists, and I assume the list that the Navy has is entirely separate from the Army. I know that the Surgeon General has a separate list from the Army commander, so I suppose it goes further than that, and I think we should have a single list."

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources

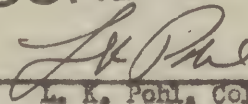
"(K) 7. I also feel that our residency training programs should be more closely coordinated; in line with the general idea of eliminating competition among the services, I think we should coordinate our procurement efforts, our inducements, bairts and everything else that we are using to get people to come in. And that is one more thing that I think I could have added in a previous question when talking about things that could be coordinated like the supply effort. I think we could coordinate our procurement effort as well to avoid outbidding one another in our effort to get people to come into the regular service, and I kind of touched on No. 8 when I talked about bidding for procurement.

"The spirit of competition is a very basic American thing. It's one thing that makes America strong, but I think that competition can be carried to the point where it becomes just frank rivalry.

"I think in case of medical officers, which are if not in critical supply, they certainly are not abundant, that it would be better for the welfare of all the armed forces—and particularly in their relation with civilian population—if the armed forces could standardize their approach to the civilian doctors. In other words, offer them the same opportunities for professional training if they wanted it, offer them the same amount of income, offer them the same grade if coming in direct from civilian life, and things of that nature which at the present time are not in actual fact. There is considerable competition.

"(K) 9. I don't visualize uniformity of all medical services on a defense level. I think that on a defense level we should have complete uniformity of medical thinking and possibly—and only possibly—of high level hospital service. I don't see how we can have common medical service at the troop and ship level in the services. The requirements are too specialized. A knowledge of the tactics and the operation of the fighting units is necessary to give proper and intelligent medical service. I don't believe that you can standardize the requirements at that level.

"In other words, I feel that each major force needs a medical service at the level of the people that are doing the fighting. I think that this would entail a certain amount of individual research and development concerning items and what not at those levels. I do think that an upper level as indicated here, the defense level—I suppose that means Mr. Forrestal's level—I think at that level a great deal of the high level medical research problems could be completely unified under one head."

RECORDER


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

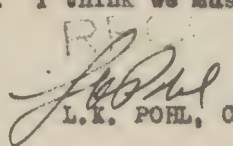
X cont 3

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources.

I therefore feel that at the top level there should be a medical director or medical man for the armed forces as an advisor to the director of the armed forces, to the Secretary of Defense, and I think that he should have an advisory staff to include research and development at that top level.

As far as No. 12 is concerned, I think that the more combined planning we do on all medical matters, the better we will be, and I think we must consider the Veterans' Administration, Public Health Service, and all the civilian organizations together. I think we must all work together on this problem. *****


L.T. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL CORNELL, MC, USA, 30 APRIL 1948

***** K. "I will go to (k) because some of these remarks refer to that. "Factors contributing to alleged overlapping of medical functions among the Armed Forces."

In small areas, duplication is apt to occur. For example, in Puerto Rico, '41 to '43, there were Army, Navy, Air Corps, Public Health, insular, and Engineer Hospitals, an island 30 by 100 miles. Construction engineers civilians sick, could not be hospitalized in the Army Hospital, so an engineer hospital was built securing materials through high priority which were needed in the other places. Medical personnel in the Air Corps Hospital were not available as re-placements in the Army hospitals. At least two large hospitals in such an area could handle all the work with dispensaries or small station hospitals at the other post to screen cases for hospitalization in the larger units, which would certainly save personnel and equipment, and I think in time improve treatment.

Specialty services could be grouped such as X-ray, laboratory, dental and so forth.

Overseas four to six medical officers were assigned to various units held at air fields where only dispensary service was given. They never went on missions except for something to do, but had to be present with that unit because it was an ATO requirement. One of the majors from over at one of the fields on the other side of Italy who was being transferred had been trying hard to get into a hospital where he could get back and do some medicine particularly gave me a story as to what they did at this air field. There always had to be three of them present on the field. There were five there; but if there was a crash and injured were brought back, they gave them dispensary service and immediately threw them into a general hospital.

I recall at one time early in the war when there was an Air Corps expansion, a small area -- I forgot whether it was Puerto Rico or Panama -- immediately 300 medical officers because there were that many officers called for in the organization of that many groups. With modern air evacuation the number of medical officers can be quickly increased almost at any point, and if cases needing specialized treatment can be flown back to a base unit where they can get definitive treatment, I feel we shouldn't scatter medical personnel at stand-by points where they are not occupied.

As I said a while ago, I believe unification basically is sound and can ultimately be completely accomplished, but that its always hard to bring various groups together who have had instilled in them for many years a pride in service, and perhaps you might say a little friendly conflict.

REAR ADMIRAL ANDERSON: You mentioned the overlapping of function so far as hospitalization was concerned in Puerto Rico. Do you have any suggestions as to what agency should coordinate hospitalization, say, in the zone of the interior, in locations like Puerto Rico, Hawaii, in other words, in areas other than theaters of operation?

Now, I might suggest that the Subcommittee have discussed the establishment of a joint medical board on a high level, say, the joint-chiefs-of-staff level, which would have the authority to establish coordination not only in regard to hospitalization, but in all other functions of medical services. Can you give us some ideas of yours along that line?

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COL CORNELL, MC, USA, 30 APRIL 1948,
K CONTINUED:

COLONEL CORNELL: I think you are right in establishing the designation as to who shall be responsible in a given area at a high level. All of the services have had inculcated in them the idea that if it comes down from above it's carried out. If it's made locally, there is always a feeling that there has been some - perhaps we might say - friendly intrigue; so that if it comes down from above that this some, which is in command of so and so, such and such a service, will be in charge of general hospitalization. Other units will establish only minor medical units and will refer their cases that need hospitalization to such and such a general hospital. Have it known as a general hospital, not an Army or Navy or Air Corps hospital; but the general hospital of such and such an area, which could be staffed by personnel from at present all of the services, but later from the medical service. I think one has been planned for at Roosevelt Roads and the large naval establishment at the east end of the Island might have called for a large hospital there, and one in the region of San Juan, and now I understand - I may be misinformed, but I think there is another hospital going up down there, a VA hospital.

I think we can save a lot on medical personnel, medical supplies, large medical equipment by having them centralized in these areas.

Now, at Saint Thomas, where we just had a few Army troops and occasionally some caretaking elements, I believe those men were taken care of in a dispensary, they called it - it was a lovely hospital, in my way of thinking, and there we didn't have an Army hospital. We didn't need one!

I think that's the thing that could be carried on, and I believe the decision should be made from a high level." *****


L. K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USN
4 May 1948

***** K. " REAR ADMIRAL WILLCUTTS: I think that is well established. I think that is a going concern.

REAR ADMIRAL ANDERSON: And do you feel also that in procurement there should be some plan which would avoid competition among the services - procurement of personnel I am referring to?

REAR ADMIRAL WILLCUTTS: I wouldn't say competition. I think competition is to be encouraged always. We wouldn't do away with football until the Navy had slaughtered you fellows at West Point for previous defeats of the past century. I think competition is all right.

I do think we can safeguard against overlapping. If in a sense we have an outstanding neuro-surgeon or an outstanding cardiologist, or somebody which the other sister services have desire of, I don't see any reason why there shouldn't be exchange of these specialists and consultants and common sense exchange of staff. As to procurement, however, I am fixed upon the point that your doctors are not going to be drafted. That word "draft" is a peculiar word. As I said a minute ago, the draft will make them enlisted men.

The only way they can draft a man is as an enlisted person, an apprentice seaman. When we register these doctors from age 45 down, then the doctors knowing that certain quotas are going to be called upon will get busy and see that we get them. Otherwise, they will be caught in the draft. So we are different on procurement. The Army has their story and we have ours. I don't know how you are going to absorb our Naval Reserves.

REAR ADMIRAL ANDERSON: The subcommittee has felt that the Reserve organization should certainly be maintained.

REAR ADMIRAL WILLCUTTS: We have a Reserve now that will meet all our needs, unless we get to a 4,00,000 man Navy. There are 14,000 doctors and they are classified. There are professional cards on them separated by divisions.

REAR ADMIRAL ANDERSON: Of course if the present draft bill becomes law the Navy will benefit by doctors who are brought into the Service as a result of that law.

REAR ADMIRAL WILLCUTTS: But we will get ours from our Wel2 pool, and the Army will get theirs from their ASTD schools. Maybe from the same school we will get brothers, one Army and one Navy. Our source of supply will be similar, but they won't be the same procurement.

In carrying it a bit further, I don't see how in the devil you can do joint procurement on your enlisted men. They say that should be done. If they were recruiting, say, in Kokomo, Indiana, which may have a quota for 10 Navy, 50 Army and so many Air Force, it is going to be a broad minded Marine who is going to let Army get a good boy that looks like he'll make a good Marine. That is just common sense.

RESTRICTED

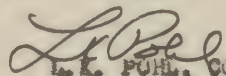
RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC)USN
4 May 1948, I CONTINUED:

Now as to physical standards, that profile system is fine. I think we should judge them alike. But I think we can have a Navy doctor and an Army doctor on recruiting to sell a bill of goods to each one. I think it's fine to keep a little esprit de corps.

COLONEL FOHL: You would recommend a complete medical service identified for each.

REAR ADMIRAL WILLCUTTS: Yes, I would, but sisterly and brotherly and with common sense, and with a wide open door for all types of patients.*****



L.K. FOHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA
13 May 1948)

MAJOR GENERAL KENNER: ***** "As to the next question -- factors contributing to alleged overlapping of medical functions among the Armed Forces -- hospitalization, medical supply, personnel and research, and similar factors, it seems to me, could be controlled by a proper authoritative and integrating or coordinating agency. This overlapping has existed and we have seen it. We had an Army hospital here, with an Air hospital there and a Navy hospital there 40 miles away. The Army hospital may have been empty, with each taking only its own patients, the other one almost empty, and the other one full to overflowing. There again you come right back to this one central coordinating agency. I think that is the only cure for it." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH BRIGADIER GENERAL JOSEPH E. BASTION,
MC, USA, (RETIRED) OF 3 May 1948.

***** K. " Factors contributing to alleged overlapping of medical functions
among the Armed Forces.

BRIGADIER GENERAL MARTIN: Off the record.

BRIGADIER GENERAL BASTION: Right now you can do a few things like
your supply, research, and then I think you can do something about the definitive
treatment of patients, hospitalization, general hospitalization. Now, you still
will have to have, I think, men trained for duty on ships, and with the Air
people for their bases and with the Army for tactical combat troops, but I do
think that right now for those things that I mentioned something could be done.*****

RECORDED

L.K. Pohl
L.K. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

D-1 16 THE CHIEF POINTS OR CIRCUMSTANCES WITHIN THE MILITARY STRUCTURE CONTRIBUTING MOST TO THE APPARENT DISAFFECTION OF MEDICAL PERSONNEL.

I. DISCUSSION

1. Any discussion or consideration in regard to apparent disaffection of medical personnel as a result of their service in World War II should begin with full realization and appreciation that during the last World War the record of the Medical Departments, as a whole, in the saving of lives and in the medical care of the sick and wounded, won the highest praise from all sources.

2. Review of the comments made by various still active and some inactive Medical Department officers who served during World War II, emphasizes the fact that this problem of disaffection was, and still is, a most important necessity for future corrective action by all echelons, Line and Medical Department, from the Secretary of Defense level on down. The comments are too universal and familiar to be accepted lightly and passed over without their prevention, insofar as is humanly possible, in any future war. It is believed that the presentations already made in this report in regard to previous subjects considered (i.e., personnel procurement methods, assignment policies, etc.) will automatically do a great deal to effect the desired end. The diversity of action required in attempting to remedy the multiplicity of complaints encountered, should be provided for in all planning during the coming months and years.

3. It is believed desirable for the purpose of brevity, that the following essential summary of the reported causes of disaffection should be presented:

a. Much dissatisfaction with policies and methods in personnel management is reported. In particular, these include procurement methods, duty assignments, rank upon being commissioned and other matters such as difficulties in promotion, prolonged overseas and sea duty for some, as compared with others, plus inconsistency in redeployment and demobilization procedures. There were evidently many irresponsible promises made by certain Medical Staff personnel to incoming officers as to rank and duty assignments which were never kept. The permitting of private practice to be continued by some "mobilized personnel" is mentioned. The family and housing conditions exaggerated by a lack of human understanding and reasonable consideration of each doctor and dentists' personal problems were believed most important. Mention is made of a cheapening of the higher medical ranks

RESTRICTED

RESTRICTED

due to comparative relative ease of promotion, when position vacancies occurred, and which obtained for some of the younger, recently civilian MC officers. Also mentioned are class distinction created by designation of affiliated units, as it existed between regular and nonregular components and as stimulated by the recently required board specialty qualifications and the instances where military duties prevented many of the younger officers from furtherance of their purely professional education along the specialty lines desired.

b. A Medical Department officer, having been professionally trained, has come through a developmental period in preparation for future public service and as an individual capable of independent thought and action in accordance with the deductions of his own mind as to the proper means for the accomplishment of a desired end. His dislike for regimentation could not always be alleviated by tactful Medical Department Regular Officers. Too often the disaffected former Medical Department officers were not aware of the part line personnel management played in the picture. Conflicts with non-medical officer personnel were reported of frequent occurrence, and often due to an abuse of command authority from which MC officers had little or no possible recourse. It can never be assumed, however, that tough bodied and tough minded laymen in Command positions will have a full appreciation of the proper functions of doctors and hospitals.

c. It was stated and it is believed true that "when medical personnel were actively engaged their morale was high", that varying periods of inactivity, an inadequacy of preparatory medical indoctrination and training, an excessive and unnecessary or unsuitable, often most arduous military training, primarily intended for nonmedical personnel, and finally, a frequent failure of recommendation for outstanding services occurred all too frequently. General hospitals were reported as being too large to allow for proper and adequate personnel administration. Conflict between various medical echelons extending to the Surgeon Generals was exposed to full view of many of the civilian Medical officers and they often were allowed to participate therein enthusiastically. The concepts of civilian medical officers of military service in peacetime, is considered to be predicated upon their wartime experiences. Dissatisfaction because of an excessive predominance of the psychiatric element in much of their clinical material evolved, because of the military stresses and other influences in war time on all patients. The necessity for rendition of medical care to civilians and which was

RESTRICTED

RESTRICTED

thought could just as well be done with the doctor again a civilian, caused such discontent for some medical officers and particularly dentists. This factor, added to a relatively disproportionate income for the military medical officer has prevailed and still exists. There is the concept held by many lay persons and existent in some of the highest positions in our Governmental structure, a nonunderstanding belief that the medical service, and particularly that for the military, is a commodity which can be bought and sold, in the same manner as done in other arts and most trades. This is based evidently upon the apparent misunderstanding that the Hippocratic oath and higher motivated ideals of the doctor make it mandatory and binding for him to accept any imposition as may be deemed expedient, in his having to render adequate care of each and every patient, for twenty-four hours a day, seven days a week, etc., and that therefore he will accept complete exploitation by the so-called business man commodity minded executive and/or commander concerned.

4. Individual opinions varied considerably in regard to primary causes for the disaffection and suggested remedies. Frequently the suggested remedy, such as some recommended changes in promotion criteria and status of Medical officers might well favor a certain few individuals and also if employed and followed through in a future conflict result in a deterioration of the quality of medical care rendered. Interference with carrying out of the primary mission of the force concerned would result eventually in a greater dissatisfaction than existed prior to the institution of the supposedly corrective measure.

It is believed particular significance should be given to the American Medical Association Analysis of Post War Questionnaire Report, pertinent extracts from which are reproduced, see page 40 of supporting data. It is here considered in view of the 5 points stated as to: "What These Doctors Want" — in brief: (a) Avoidance of Medical overlapping; (b) Professional duty assignment; (c) Avoidance of any needless excessive number of doctors from civilian service; (d) Professional ability rotation and (e) Military hospital construction with adequate consideration of possible civilian wartime requirements; that the Force Medical Department Staffs concerned must give adequate continued attention to appropriate phases of these points in their future planning and operational activities.

II. CONCLUSIONS

1. A disaffection of the civilian medical professional groups for the Armed Services after their service in World War II, although partly concurrent with and resultant from the general

RESTRICTED

RESTRICTED

antagonistic reaction during demobilization, nevertheless, was and must be considered as persisting, to a most significant degree and particularly among civilian doctors and dentists.

2. The causes of disaffection, although most multiple and individual in degree as applicable to each former medical member of the Armed Forces, are deemed susceptible to marked lessening and correction if analyzed and followed through with such intent, Command realization plus their full cooperation, and the avoidance in Medical echelons, of all possible duplication of similar errors in regard to medical personnel management as reportedly occurred in World War II and as can be humanly accomplished is demanded in preparation for and during future National Emergency.

3. It is believed that there has not been adequate mention made of the good and favorable accomplishments and extreme consideration given to many former medical officers serving in World War II upon their entry, during their service and to allow for their separation, as was accomplished by the Regular Military Medical Establishment. In the minds of most of these so favored former officers are many memories of assistance, guidance and all possible favors as could have been given them so as to render their tasks easier, in their adaptation to the multiple, unusual, vigorous demands of military life in war.

4. The lack of revised promotion policies, especially for members of the inactive reserve, is deemed an important requirement for most careful analysis and action. The relative success of the old Regular Army promotion system, based upon length of service provided accord, minimum jealousy and a security unparalleled by civilian medicine during the thirties. The "running mate" system of the Navy, insures opportunity for promotion to the MC officer in sequence with the non-medical officer component.

III. RECOMMENDATIONS

1. Policy definition to allow for maximum administrative and operational control of medical department activities and particularly medical personnel management by the Medical Department of the Armed Forces concerned.

2. Continuing Armed Forces Medical Department analyses and corrective action indicated against those conditions which caused disaffection as are reported and available in detail by perusal of the supporting data.

3. Coordinated planning directed toward possible revisions of current provisions for rank and pay of Medical Department Officer components of the Armed Forces during National Emergency.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter - Colonel John A. Rogers, MC, USA, Retired - dated 19 April 1948.)

" The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel. Perhaps the most serious complaint in this category was the assignment of medical officers to combat divisions for periods of several years. A serious effort was made in the European Theater to provide some rotation which was difficult to accomplish at best. The average doctor likes to practice his profession and this is very difficult during the long training periods with combat troops. It is believed that many good men who were qualified but had not had the opportunity to obtain specialist's rating were utilized in spots not commensurate with their abilities. This undoubtedly created much dissatisfaction. On the other hand, it is appreciated that in mobilization of this magnitude that individual injustices are inevitable. Every effort should be made, however, to have the speed of mobilization of medical personnel keep pace with the actual training and tactical requirements."

TRUE COPY EXTRACT (Letter - Colonel Arthur B. Welsh, MC, USA, - dated 19 April 1948)

" The position of The Surgeon General in the Army Service Forces and his inability to advise concerning and influence the medical service armywide cause the greatest disaffection because of its ramifications. There was too much lost motion in effecting coordination. High command did not always avail itself of medical counsel.

" The Surgeon General in World War II had definite responsibilities by law but he didn't have the authority to discharge his responsibilities because of his position in the Army Service Forces.

" There wasn't a 'Medical Monitor' who could issue orders in the name of the commander and make the medical service function efficient and insure the conservation of medical means.

" Too much shopping around for jobs was permitted. The medical officer who came in early often got in a T/O spot and was permanently stymied while the less capable doctor waited until higher initial missions were offered either by the Navy, Air Forces, or Army, then came in to a better position than that occupied by his better qualified confrere of longer service who was frozen by the T/O of his unit.

" Implementation of rotation between tactical and service units both in the zone of interior and overseas was planned but not enforced and cost heavily in morale and post-war doctor good will.

RECORDED
L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT - Continued - Col. A. B. Welsh, MC, USA

"Failure of rotation between overseas and zone of interior positions made doctors feel they were being discriminated against.

"Affiliated units created class distinction. Board certification may do this in the future if permitted to be the principal criterion of assignment.

"The emergency medical officer thought there was too much control over his activities by non-professional officers. There is wisdom in medical command.

"Theater army and communication zone surgeon positions were not always filled by the same individual.

"There was no single power at any level that could move outstanding medical personnel without line concurrence. There should be, provided a numerical replacement is furnished."

TRUE COPY EXTRACT (Letter - Colonel F. A. Blesse, MC, USA - dated 19 April 1948)

" The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel.

" a. Poor training. Many of our war-time officers hated their jobs because they did not know what to do. As a result there was inefficiency, idleness and brooding, and now, in peace time, there is antipathy. Experienced military men know that battalion and regimental surgeons, clearing company commanders and the like are the 'shock troops' of the medical service. What they do, and how they do it, influences the operation of the entire system of medical evacuation and treatment. Yet these men were not, as a rule, adequately trained for their work or properly indoctrinated; if they had been, they would not have felt degraded by serving with the combat troops and would have realized its importance to the combat effort.

" b. Lack of consideration for personal feelings. I believe it can be truthfully said that medical officers are more callous in dealing with each other than are officers of other branches. There are numerous examples of unnecessarily stringent regulations, harsh efficiency reports, failure to make dispensary service attractive by permitting minor surgery to be done, unwillingness to rotate doctors between hospitals and dispensaries, frank discrimination because of professional jealousy, etc. Every medical officer should be made to appreciate his unselfish responsibility for the development and career management of his junior officers.

" c. Stagnation in grade. This is a fundamental defect in our promotion system. The British Army system, whereby an officer is given the grade authorized by his position, is worthy of serious consideration. This system prevents an accumulation of excess officers in the higher grades, makes it possible to reduce an inefficient officer without complex administrative procedure, and rewards the capable officers by giving them rank commensurate with their duties. It also emphasizes the basic concept that rank is a symbol of responsibility, not a

RESTRICTED

RECORDED
L.K. Pohl

L.K. Pohl, Colonel, MC

699

RESTRICTED

TRUE COPY EXTRACT - Continued - Col. F. A. Blesse, MC, USA

compensation for time served.

" d. 'Patriotism does not pay'. Those doctors who stayed at home worked strenuously, but made their fortunes. On the other hand, the longer a doctor stayed in the military service, the more he and his family sacrificed economically. Some means of equalizing and minimizing the inconveniences should be devised. The most satisfactory solution that comes to mind is federalization of medicine during an emergency. This, however, would evoke loud protestations from the entire medical profession and all their prospective patients, even though several millions of people in the Armed Forces would live under federalized medicine. It is probable that this problem could best be approached from the civilian angle, by one of the committees of the American Medical Association.

" e. Among the younger generation, including doctors, there appears to be a need for some old fashioned patriotism and an understanding of the importance of unselfish service to the country in time of emergency. Sacrifice and hardship must be expected in time of war and it hits some harder than others. Medical officers sometimes failed to see how much more many others sacrificed. Those who did not have the advantage of a commission and whose families suffered financially while they endured real hardships. Many of these were professional men, merchants, etc., who served as enlisted men and lost everything because of the war. Less was heard from these than from many who had less reason to complain.

" f. Reference could be made to complaints heard regarding promotion, assignments, rotation, waste of their talents, prolonged periods of field duty compared to others, discipline, regimentation, periods of inactivity, etc., but they should serve only as a guide to our studies for possible corrective action. In my opinion, most of the criticism comes from a few disgruntled and poorly informed reserve officers who obtain more publicity than the actual majority whose ideas differ. I am convinced that this is not the opinion or attitude of the majority of reserve officers who saw service in the last war. A post-war antagonism to everything military seems to be a normal reaction which gradually diminishes. Good constructive criticism should always be welcomed and carefully analyzed to determine corrective action required."

TRUE COPY EXTRACT (Letter, Colonel Richard T. Arnest, MC, USA - Retired dated 19 April 1948)

"There were many points contributing to the disaffection of medical officers. Among these were promotion, inequities - time in grade and position vacancies was farcical, long periods of inactivity - doctors are accustomed to being busy.

RESTRICTED

RECORDER

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT - Continued - Col. R. T. Arnest, MC, USA

"These officers brought in during 1940 and 1941 should have been promoted at the end of their first year. They saw in 1942 their classmates come in as Majors and Lieutenant Colonels while they still remained 1st Lieutenants and Captains. Of course they griped and it was passed on to other members of the medical profession.

"Medical Officers by the dozens were placed in replacement pools and left there for months. I knew several cases where they were there more than a year. These officers should have been utilized by putting them on duty at a hospital, promoting them if they were worthy and not keeping them waiting and hoping to get into a position that carried a higher grade.

"After the war years in the United States the chief concern of officers seems to be a place to live where they could have their families with them. They still complained bitterly of all of these other things that were wide spread throughout the Army. There are others that I don't have time to mention."

TRUE COPY EXTRACT -(Letter, Brig. General Guy B. Denit, MC, USA
dated 13 April 1948)

"The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel - One of the chief points was that the staff could not be impressed with the fact that it was an is essential that the Medical Department have more autonomy in running and administering its own affairs. It is believed essential that there be a branch allotment on a percentage basis for Medical Department personnel, officers and enlisted men and women; that there be a percentage of grades from general officers on down allotted to the Medical Department; that Medical Department T/O units be prepared in advance and approved by the Department for all eventualities and that these Medical Department units be placed under the command of the Sr. Medical Officer on each staff; that the Medical Department be excepted from personnel policies and procedures which establish bulk allotments for camps, stations, tactical organizations and theatres of operations."

RECORDER

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Robert P. Williams, MC, USA
dated 16 April 1948)

"The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel.

"This subject may be discussed interminably. The universal draft, with assignment of every individual to military or civil posts in accordance with the requirements, would cure most of these ills. Also it is believed that this draft would increase the feeling that everyone is serving, decrease the present selfish attitude."

TRUE COPY EXTRACT (Letter, Major General M. C. Stayer, MC, USA-Retired
dated 19 April 1948)

"The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel.

- "1. They were not used for professional work and were used as members of Boards of Inquiry, Investigation Boards and investigating officers other than which concerned medical or surgical problems.
- "2. Members of General and Special Courts Martial, which was considered wasting their and the government's time.
- "3. Filling administrative positions as executive officers for evacuation hospitals, convalescent hospitals, station hospitals, registrars, and adjutants for hospitals of the general hospital level.
- "4. Lack of promotion.
- "5. Commanding officers who were poorly selected and forgot they were still doctors."

RECORDER

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Brig. Gen. R. C. McDonald, MC, USA, Retired
dated 15 April 1948)

"The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel.

(1) Comment: Disaffection of medical personnel, particularly medical officers, results from:

a - Malassignments: Too often medical officers are not assigned according to professional ability - too much administrative work is the complaint of many physicians;

b - Too much purely military training, particularly for medical specialists;

c - Lack of, or inequalities in, promotions;

d - Idleness enforced by campaign conditions;

e - Delay in demobilization."

RECORDER

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee - (formerly Air Force)
dated 18 April 1948.)

"The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel.

"The dissatisfaction is not only apparent but real and often well founded. The principal gripes are lack of professional opportunity, lack of any real duty, subordination to high ranking, but professionally ignorant commanding officers, the inequities of rank (rank should be abolished in the medical service, all should be 'doctor', pay should vary with position held not with rank), resentment against malassignment, sense of futility when confronted with organizational rigidity."

TRUE COPY EXTRACT (Letter, Dr. A. R. Shands -(formerly Air Force)
dated 20 April 1948)

"The chief circumstance which lead to disaffection of medical personnel was the lack of proper assignment and the failure to obtain promotions when the personnel thought they were due. I personally believe that all rank should be abolished in the military medical services. A doctor's prestige on a post even though he might be an excellent physician was not what it should be if he did not have comparative rank to non-medical personnel. This had a tendency to lead to lack of respect on the part of the layman for the doctor."

RESTRICTED

RECEIVED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Captain Lewis T. Dorgan, (MC) USN - no date)

"The chief points or circumstances within the military contributing most to the apparent disaffection of medical personnel."

"The irregularities in promotions of Medical Officers, and changes in policy caused a great deal of disaffection during the last war. The designation of rank based on age was extremely unfair to those doctors who came on active duty voluntarily. Some who were 36 years old remained lieutenants for over two years, while their colleagues who remained at home until forced in by selective service, attained their 37th birthdays and were inducted as Lieutenant Commanders.

"The sharp distinction drawn between regular and reserve Medical Officers caused the latter to feel that they were not an integral part of the Medical Corps, and they frequently displayed this attitude through lack of cooperation with various administrative policies.

"Some Medical Officers, both regular and reserve, show marked administrative ability, others are of value only in professional positions. The greatest economy of effort and talent could be achieved by dividing the corps into an administrative and a professional division. This division would be based upon experience, personal preference, suitable proof of specializations (American Board Certification), and various psychological aptitude tests. An alternative to this division might be to keep the majority of medical officers in professional work and to delegate most administration to a highly trained non-professional group of hospital administrators. This latter group would be composed of University graduates who had completed a prescribed course in hospital administration as offered by several of the larger Universities at the present time.

Suggested Remedies:

- (1) Grant rank on the basis of experience and ability, not on age.
- (2) Minimize the distinction between members of the Regular and Reserve Medical Corps.
- (3) Promulgate definite policies of promotions, rotation of hazardous duty, release from active duty, and length of tour of sea and foreign shore duty.
- (4) Establish administrative and professional divisions, the distinction to be made on a basis of experience, ability, personal preference, and showing made on psychological aptitude tests.
- (5) Utilize trained hospital administrators so as to free more medical officers for professional duties.
- (6) Avoid idle pools of medical department personnel. Place pools and staging personnel where their services can be utilized while awaiting forward movements."

RESTRICTED

RECORDED

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Robert M. Gillett, MC, USN
dated 15 April 1948)

"In my opinion, the chief causes of disaffection of medical personnel was the failure of certain commands to take the medical officers into their confidence during the planning stages.

"Unemployment of medical personnel between actual combat duty played havoc with morale. This fault could have been remedied, at least in part, if reassignment and utilization of personnel had been delegated to some of the lower echelons. All war plans should give more consideration to this problem. In my opinion, more war neurosis developed during the free interval than actually under combat conditions."

TRUE COPY EXTRACT (Letter, Captain Warwick T. Brown, (MC) USN
dated 20 April 1948)

"During World War II in my contacts with several hundred medical officers assigned to the Fleet Marine Force in the Pacific, I rarely encountered a medical officer of the regular service who expressed dissatisfaction or discontent with his lot. They were uniformly the key men in the medical organization. They could always be counted upon to do more than their duty. A small minority of the reserve officers were dissatisfied, principally with military life in general and because they felt that their talents were not being utilized to the best advantage. Particularly this was true of those whose specialties could not be practiced in the combat forces. Since the war and among the younger officers performing obligated service, the main reasons for dissatisfaction with service in the Navy Medical Corps are as follows:

- (1) The desire to early and uninterrupted completion of requirements for certification by a specialty board.
- (2) Family objections to the nomad type of life of the military man.
- (3) Dislike of regimentation and dissatisfaction with their lower rank in comparison with line officers of the same age group.
- (4) Economic. The fact that most of them can or believe they can make more money in civilian life.

RESTRICTED

RECORDER

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral W. H. Michael, (MC) USN Retired
19 April 1948)

"The number one cause of disaffection of medical and all Naval personnel in World War II and before and after World War II is the established rule of the Navy to regard the authority and acts of commanding and superior officers as sacrosanct and failing to investigate all reported cases of mental sadism or near-sadism until the lives of many men and officers were made unhappy, men and officers are made to detest the Navy, to resign or desert or even to commit suicide. These cases may not be very frequent, neither are they unusual and every one remains indelibly fixed in the minds of the victims who are ever ready to broadcast their bitterness.

"In my opinion, what is called 'loyalty' is over-emphasized in the Navy until frequently personal loyalty to officers is placed above the efficiency of the unit and loyalty to the nation. In my experience officers always get as much if not more loyalty than they deserve from those under them. The reverse is not always true. Personally, I attribute the only unsatisfactory fitness report I received in 32 years of naval service because I asked that the methods of procedure of an officer - and one junior to me - be investigated because 'in my opinion they were detrimental to the mental health of the staff and thereby to the efficiency of the command'. I enclose a reprint written before this incident which covered my views in 1942. These views have been confirmed and extended until I feel that the greatest fault in the Navy in handling personnel is a lack of human understanding, on the part of many officers, and their mistaken idea that toughness - even illogical toughness - means the same as efficiency. My suggestion for correction is either the appointment of a mentor or investigator to detect any condition as described and recommend action, or promptly investigate any report or rumor of mental sadism or gross inefficiency. And above all, to stop the nefarious custom of reacting to a complaint by punishing the complainer rather than investigating and correcting what is wrong.

(2) A cause of disaffection is failure to make a concerted effort to teach the newly mobilized medical officer or enlisted man about the Navy, to put him at ease and at home in his organization as briefly described under Paragraph (B) above. The correction is the adoption of training along such lines. It is particularly important to make formerly busy civilian doctors understand that inactivity of doctors in war especially in the field is not only to be expected but to be hoped for because it indicates success in preventive medicine and/or military strategy - fewer sick, fewer wounded.

(3) Excessively frequent changes of duty which gave the newly mobilized doctor a feeling of instability, and of 'not belonging'. Correction is obvious.

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT - Continued * Rear Admiral W. H. Michael (MC) USN Retired

"(4) Numerous injustices in the selection of medical officers for active duty, putting to many obvious economic and professional disadvantages those who volunteered or were selected. To reduce this cause as far as possible, it is suggested that only doctors over 50 years old and those with obvious incapacitating physical defects be declared 'essential for civil population'.

"(5) Failure to terminate the private practice of some 'mobilized' doctors either by prohibition or transfer to other localities, while less favored do not have that privilege. The correction is obvious."

TRUE COPY EXTRACT - (Letter, Captain C. D. Middlestadt (MC) USN dated 17 April 1948)

"Answering paragraph 3(1), I consider the following one of the factors contributing to dissatisfaction of medical personnel. BuPers would order a Lion Unit or a Fleet Hospital to be prepared. Orders would go out to assemble the medical personnel. Many times the officers and men would wait for months at a seaport before being moved. The officers would have nothing to do but to play cards to pass the time away. They were anxious to do medical work but all they could do was to wait and wait. It would appear that the schedule could be made and the officer informed that he was to be detailed to this unit and for him to hold himself in readiness for such orders on seventy-two hours notice. Then allow him to continue his medical services as an additional number where he is on duty. This would allow him to remain with his family and to do medical work in which he is interested. It would reduce the burden on under staffed hospitals for a period. This was one of the chief complaints expressed to me. They said they had joined the Armed Services to give their medical services and it was not being utilized.

"There should be a better system in the assigning of rank. During the past war physicians who volunteered early were later to learn that their colleagues who had remained in private practice for a year or more were given a higher rank than they held after having given a year of service. Some physicians who had been taught in medical schools by older physicians of high standard were given senior rank to these older physicians in the service. They had held out and offered a high rank by Bureau of Medicine and Surgery in order to get them to enter the service. Some form of draft could eliminate this bad procedure.

RESTRICTED



L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT - Continued - Captain C. D. Middlestadt (MC) USN

"Hospital corpsmen should be kept in hospitals as extra numbers or under instruction instead of doing manual labor in Lion Units or Fleet Hospitals, which are being assembled. This manual work should be performed by AF or negro labor battalions and not by highly trained personnel. If an individual has enough pride and energy to improve himself he should not be forced to do manual labor especially in the United States. At the front it may be necessary, where limited transportation would limit man power.

"If the Navy intends to train V-12 men in the future, there should be some understanding that they will be required to give some service to the government. I have been informed by V-12 officers who have had to remain in the service, that there were some three thousand who received most of their education at government expense, but were not required to enter the service. This is unfair to those that were compelled to remain. Also there should be some consideration given in releasing these officers. An Alnav gave permission for these officers to request their release without any reason. If a medical officer had a reason to be released he was held in service, those without any reason were released. This kind of treatment is no selling point for the regular naval officer in trying to build up the reserve corps.

"The department should stop making promises unless they are prepared to fulfill these promises. I know of nothing which kills the morale any better than to fail in carrying through our side of an agreement. It should be remembered that we are dealing with educated and honorable men and not the lower classes of individuals.

"If possible some kind of indoctrination should be instituted whereby line officers who graduate from the Naval Academy would realize that their four years of instruction in a secondary college does not give them a medical degree. Too many line officers feel they know more medicine and sanitation than a medical officer, who have spent from eight to ten years obtaining their knowledge and with as much service as the line officers. The opinions of the medical department is too often disregarded. I have no solutions to offer, to correct this condition."

RECORDER

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT - (Letter, Captain Alfred W. Eyer (MC) USN
dated 17 April 1948)

"The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel.

"Opinions relative to the subject have been largely covered in foregoing comments.

"In addition, it may be stated that much dissatisfaction arises in the Naval Medical Service from the inability of the young medical officer to envisage the full extent of his career. This is partially psychological induced by rosy reports of the status of his civilian contemporaries. Probably, the two greatest factors are type of service and financial remuneration.

"The latter is frequently brought to the fore by junior officers who do not feel that they can get along reasonably on service pay; and, who are sure they cannot get along on service pay when comparison is made with reported incomes of civilian physicians with comparable experience.

"The type of service offers many pro and con arguments. However, the requirements of the services, incident to organizational training, which separate young men from their families or the potential establishment of families is a strong deterrent against both entering into and remaining in service organizations. In this respect, it must be remembered that young medical officers are more mature than the usual run of officer or enlisted personnel at entry into the service.

"Much of the dissatisfaction incident to this is believed to be temporary and resulting from the current economic and housing facility situation in the United States.

TRUE COPY EXTRACT - (Letter, T. F. Cooper - dated 19 April 1948)

"Points that have given rise to disaffection among medical personnel are many. War is unpopular and on termination of hostilities there is a tendency to separate one's self quickly and completely from any service connection. Differential between service pay and pecuniary rewards in civil practice is too great. Sea duty and duty at small stations, recruiting duty, etc., are not appealing to the great majority of medical men. Ideas of peacetime service are often based on experience during war service wherein long periods of separation from family and friends, often in remote areas with only trivial medical duties, obtained. Increase in educational requirements and costs of obtaining same are deterrents to service interest. Service interns, if given a regular commission on completion of internship, should be given full credit for longevity and pay purposes for the time spent as an intern."

RESTRICTED

L. K. Fohl
L. K. Fohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel O. F. McIlroy, MC, Air Force
dated 20 April 1948)

***** "1. There is apparently a very definite disaffection of medical personnel for the services, that is, on the part of those who served during the war. There are several definite factors which contributed to this disaffection, as follows:

"(1) Mal-assignment of specialists.

"(2) Wastage of professional talent by requiring them to perform administrative tasks and through assignment of excessive numbers of personnel to certain organizations with the general idea that their services might sometime be required. Physicians and surgeons do not resent being called upon in time of war to function as physicians and surgeons, but they do as a group resent being called upon to perform military administrative functions for which their professional training is unnecessary.

"(3) Failure to properly recognize professional responsibility as equal to administrative responsibility in the matter of promotions. Many medical officers who had spent years of hard work and a great deal of money to prepare themselves for a professional career were stymied in low grades because of inadequate provisions for their promotion, and while in these low grades, they observed many youngsters whose only training for their military occupation had been provided by the government passed them up in rank by several grades. In case we are ever again to call these highly qualified professional people into the service, adequate provisions should be made for acknowledgment of their value to the service and the only proper acknowledgment appears to be through their being given appropriate rank." *****

RESTRICTED

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Robert E. Peyton, MC, USA
dated 19 April 1948)

"****Much of the disaffection resulted from failure to realize that the medical service of a theater cannot be blown up and deflated like a toy balloon or distributed like tacks on a map or given just the right number and type of casualties to keep medical units and their personnel comfortably busy. We must also remember that free speech and rugged individualism is a national heritage. Rivalry for promotion is a potent factor. Further, the possibility of stimulated disaffection has become increasingly more important since the cessation of active hostilities. ****

"****When we pull men away from their homes and send them into the far corners of the earth and place them in a team wherein each one does not occupy the lefty position to which he thinks he is entitled -- if under these conditions they no longer complain -- then we will have already reached the millenium, and there will be neither war nor tables of organization!"

RECORDED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain R. F. Sledge (MC) USM
dated 26 April 1948)

***** "The Chief Points or Circumstances within the Military Structure Contributing Most to the Apparent Disaffection of Medical Personnel.

"Having interviewed Medical Officers in considerable numbers, there were two situations found which contributed markedly to discontent among Medical Officers.

"(1) The long delay between reporting at a port of embarkation and sailing date. During this period the Medical Officers became dissatisfied and very critical of this delay. They were partially employed in checking their supplies and equipment, inoculations, etc. but most considered this task was wasteful use of medical talent. Part of the delay was due to change in plans or military situation in the forward areas but the greater part was due to assembling personnel too far in advance of sailing dates.

"(2) The second series of complaints occurred from Officers and men attached to hospitals, dispensaries and stations located in rear areas where military operations had moved forward leaving the area with few men and fewer patients. This was especially true of those medical facilities located in the South and Southwest Pacific. Hospitals in these areas, however, were required to reserve beds for patients from the combat zones and could not be prepared for forward movements until sufficient emergency beds were provided elsewhere. Line of patient evacuation was towards the continental United States rather than into the hot humid South because patients morale was lowered when traveling away from and improved when traveling towards home.

"There were a few misfits who talked loud and long regardless of assignments. These individuals were transferred frequently because Commanding Officers would request their detachment after a short tour of duty. A considerable number of Medical Officers were listed as specialist when assigned as listed could not do the job required."

RECORDER

713

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C. B. Cameron (MC), U.S.N.,
Retired dated 21 April 1948)

****(1) The indiscriminate and excessively rapid promotion of various Reserve MC's, thereby cheapening rank and working a great hardship on Regular personnel is to be deplored. At the same time a lessening of the value and regard for rank among the Reserve recipients inevitably occurs, they being in the Service for a brief period only, naturally look askance at such tactics and tend to regard it as something too easily acquired. At the same time the unfortunate Regular, who has come up the different rungs of promotion the "hard way", is left far behind and in the eyes of many temporary officers, by the very manner of their own rapid advancement, is definitely inferior to them, professionally and otherwise. This, in turn, creates mis-understandings, envy, suspicion, favoritism and general impaired efficiency, with a corresponding loss of respect and lessened regard for the Regular MC, as well as the latter's resentment and antagonism to the Reserve officer, who he can but regard as unduly favored beyond his brother Regulars, likewise definitely impairing general medical efficiency.. Personally, I consider this matter to be of great and vital importance in re morale, medical cooperation - teamwork - and efficient task performance.****

L. K. Poll

L. K. POLL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

**** "1. It is my belief that the following are some of the factors contributing to the disaffection of medical personnel:

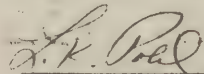
"(1) Many medical officers avoided command responsibilities, and many refused or failed to perform proper command functions when by virtue of seniority they were placed in command. This resulted in many command prerogatives being taken away from the medical department.

"(2) Medical personnel were commanded by non-professional individuals who demonstrated their inferiority frequently by rendering decisions affecting professional matters about which they were entirely ignorant.

"(3) Specialists (well-qualified) were frequently mal-assigned, and specialties were discriminated against, i.e. Hospital Staffs were set up in Tables of Organization that would not permit promotion, i.e. Ophthalmologists, Oto-rhinolaryngologists, Urologists, Dermatologists, Obstetricians, Orthopedists, Cardiologists, Gastro-enterologists, etc. were classed as subordinates to general surgeons and internists and were never promoted except in instances where they were mal-assigned.

"(4) Many medical officers, volunteers, were made promises prior to their volunteering that could not be kept and should never have been made. Many officers who were unfit for field duty were never considered for anything else and vice-versa. General hospitals were too large to be well administered by one commander. It would be better where more than one hospital is to be established to have a general hospital limited to 1000 beds and establish a hospital center with one commander in command of as many 1000 bed hospitals as would be required at that center; each hospital to have its own staff, etc. Many officers and enlisted personnel became submerged or lost in the large general hospitals.

"(5) Enlisted personnel (Technicians and Medical Specialists) were frequently transferred from Medical Department to Line Branches without apparent reason, disrupting a smooth running service.



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT - Continued - Colonel C. J. Baker, MC, Air Force

"(6) During the past war, one of the greatest causes for disaffection was the constant wrangling between the Surgeon General and the Air Surgeon. Being on duty with the Air Force since 1920, I am biased in favor of that Branch; however, the Air Surgeon was not permitted to have under his control a general hospital. The various station hospitals of the Air Force were as a whole well staffed; by that I mean staffs were carefully selected and well balanced. Many of them received certificates of approval from the American College of Surgeons, nevertheless, an order was published prohibiting major surgery, and such procedures as the reducing of a fractured long bone in a station hospital.

"(7) Very few hospitals were permitted the Air Force overseas. What few that were placed on detached service were not manned by personnel having any Air Force indoctrination. This operated to produce disaffection in two ways, i.e. it placed personnel that did not want duty with the Air Force on that duty, and it prevented hospital staffs organized and trained at Air Force stations from proceeding overseas with Air Force units. They had to go overseas with Ground Forces or be broken up and go as tactical personnel with Air Force units or go as individual Air Force medical replacements.

"(8) Many unpleasant incidents were experienced by medical officers, well qualified professionally and otherwise, at the hands of much younger inexperienced, uneducated and ignorant Line Officers of less service, but with higher rank, merely because of the differences in rank and command prerogatives improperly used.

RECORDER

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel R. E. Stone, MC (Res.) Air Force
dated 22 April 1948)

***** "The screening of Physicians and Dentists should be more carefully conducted with special attention being given to physical disabilities which disqualified some from active service. Many were judged physically unfit for active duty due to such ailments as hay fever, gastric ulcers, low back pain, trick knees, etc. and stayed home only to build large remunerative practices at the expense of those who answered the call of their country. Personally see no reason why many of these young men could not have been inducted on limited active duty status for duty in the ZI and thereby release those physically able for overseas duty. Wish to impress on the readers that this statement is not to be misconstrued as 'sour grapes' on the part of the undersigned since it in no way applicable to my particular circumstances. Only mention it because this situation has been a bone of contention to many doctors discharged from the service and has led to an unhealthy relationship in the profession in general which I feel reflects directly back to the Service." *****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain H. D. Templeton, MC, USN
dated 23 April 1949)

***** "(1) THE CHIEF POINTS OR CIRCUMSTANCES WITHIN THE MEDICAL
STRUCTURE CONTRIBUTING MOST TO THE APPARENT DISAFFECTION
OF MEDICAL PERSONNEL.

In the vast number of instances of dis-satisfaction among medical personnel, the cause was usually a personal problem. Either lack of or inadequate housing for the individual's family created serious problems on numerous occasions. Frequent transfers from one activity to another was the cause of much discontent.

Not infrequently medical personnel were misassigned, and their services could have been employed to a better advantage in the specialty for which they had been trained.

Long periods of sea duty were objected to by many of our personnel.

The lack of knowledge of medical department administrative procedures was quite confusing to our reserve medical officers and their distaste for this type of duty was most apparent.

The delay in separation of medical personnel resulted in several unpleasant instances and brought about an unwarranted disrespect for those responsible for the policies of the Navy Department." *****

RECORDED

RESTRICTED

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY (Extract from -tr Col Harry G Armstrong, MC, 16 April 1948)

**** #1. The Chief Points or Circumstances Within the Military Structure Contributing Most to the Apparent Disaffection of Medical Personnel.

(1) Defects:

- (a) Regimentation.
- (b) Military red tape.
- (c) Professional stagnation.
- (d) Assignments to small units where services are not properly utilized.
- (e) Over-staffing of hospitals.
- (f) Performance of non-professional military duties.
- (g) Frequent moves.
- (h) Economic losses.
- (i) Failure in promotion when in a T/O organization.
- (j) Dissatisfaction with command channels.
- (k) Advancement through personal or political pull.

(2) Remedies:

- (a) A complete and thorough reevaluation of the position of a doctor in the military service, with emphasis being placed on his being first a doctor and secondly an officer, instead of vice versa.
- (b) Promotion system based on merit.
- (c) Better medical planning. "

RECORDED
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain J. H. Robbins, (MC) USN
dated 26 April 1948)

***** "It was my privilege to talk to several hundred Reserve Medical Officers throughout my two tours of duty in the South Pacific in an endeavor to make transfers to the Regular Navy. Reasons for not desiring transfer to the Regular Navy as a whole fell into the following categories:

- "(a) That the assignment of Regular Navy Medical Officers was not based on their ability.
- "(b) The frequent moves made necessary by change of duty orders.
- "(c) That a line officer could interfere with the decisions of a medical officer.
- "(d) The fact that many reserve officers spent their entire war service in the States and some without ever leaving their original Station, while many others were kept in the forward areas, or at least out of the States, for practically the entire period." *****

RECORDED
L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr LeRoy A. Wylie, Captain (MC) USNR, 3 May 1948)

*** " As a constructive effort to assist the subcommittee in the accomplishment of its mission, the following personal views are also submitted under the heading (1): "The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel." These views result from contact and experience with Reserve medical officers over a period of thirteen years' affiliation with the Medical Reserve Corps, encompassing six years of active duty in two wars.

The varying criticisms relative to deficiencies and malemployment of military medical personnel arises generally from (1) personality conflicts (2) failure of adjustment to the service and (3) lack of full understanding on the part of the individual, of the specific duties of his assignment as a Naval officer.

1. Personality conflicts were observed more often among the older group of Reserve medical officers, than the younger. Study of the problem, revealed that civilian medical training and the practice of medicine influences the thinking of the individual to the extent that he is an individualist in thought and accustomed to assuming responsibility.

When subjected to restraint of the chain of command procedure of the Navy, frustration, loss of interest and personality conflicts followed. Rarely, are the professional qualifications of a medical officer at fault or questioned, yet he is frequently criticised for lapses of duty in the performance of collateral duties, such as O.D. watches, Material and Medical Survey Boards, inspections and Court recorder jobs which are a part of the life of a Naval medical officer, producing a marked dissatisfaction because he has had no training in these duties.

2. Failure of adjustment to the service. The majority of Reserve medical officers are above average in intellectual capacity and adjust themselves readily to the medical contingencies of the service. The cause of many failures of adjustment result from rank irregularities or lack of clinical work rather than monetary reasons.

The medical officer is thinking in terms of professional qualifications and achievements acquired in civilian life as basis for appointment and promotion, while age and length of active duty service is the yardstick of the Navy for appointment and promotion.

When a remedy for this situation can be found which would also be fair to the medical officer who has made the Regular Service his career, it is believed that the failure of adjustment will be minimized.

3. A reserve medical officer's lack of understanding of the specific duties of his assignments is a frequent source of annoyance to his superior officers and in the mind of the individual.

No other group of professional or semi-professional men find it so difficult to understand the details of Naval procedures associated with a medical officer's assignment, either "ashore" or "afloat", as the Reserve doctors.

RESTRICTED

RESTRICTED

This may be explained in part at least, by his professional, specialized training outside of the Navy. His years of effort to attain the highest possible degree of efficiency in his specialty, removes him far from the versatility of medical practice necessary in a Naval medical officer. Thus, his lack of versatility presents a situation of inefficiency in the judgment of the Line Officer in Command, and his medical colleagues.

Programs of training for other groups of inactive officer Reservists are most attractive and successful; whereas, for the medical officer they are the opposite, because of the confinement of a civilian medical practice and his training in daily work. He therefore, comes to active duty with little or no idea of Navy customs other than through the reading of a Correspondence Course--the importance of which is so frequently overlooked by the average individual.

If we assume the above observations to be true, the following contentions may be discussed:

(a) That means be provided for the utilization of Reserve medical officers in capacities where their professional training may be used to the maximum; thereby diminishing the necessity for so large a number of this type of personnel. That a policy be established whereby recognized specialists and consultants be utilized as teachers and for the benefit of Naval personnel with a minimum of administrative assignments.

(b) That means be provided administratively, within the provisions of the Reserve Act, that Reserve medical officers take precedence among members of their own Corps and that promotions be separate from that of the Regular Service, based on professional qualifications, by selection and in accordance with percentage established by the Secretary of the Navy.

(c) That means be provided, in the event of mobilization, that a certain number of medical Reserve officers be assigned duties in coordination with Civilian Defense, alerted for call when needed, but left in their communities; thereby, avoiding the loss of thousands of man-hours caused by personnel pools prior to the commissioning of ships or activation of advanced bases.

The Training Program now in effect, affords members of Medical Divisions (inactive), the opportunity to receive instruction in subjects peculiar to Military Medicine.

If these contentions could be realized, wholly or in part, it is believed that repetition of past mistakes would be obviated, and that the Naval Reserve Corps would continue to procure the most highly qualified members of the medical profession."

RECEIVED
L. K. FOX
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Rear Admiral A. H. Dearing (MC), USN
dated 26 April 1948)

***** (1) The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel. ***** Conversations with various Reserve officers now inactive since the cessation of hostilities and with officers of the V-12 group have brought out the following facts.

1. Reserve medical officers in the Navy during the war were in many cases displeased at promotion policies. Many have stated that "they knew of" highly qualified doctors who were professors, and were not promoted, while younger men who were often their students in their civil life were promoted to ranks above them. At the present time Reserve officers on inactive duty are interested in their promotion and have been unable to obtain any firm expression of policy regarding promotion of medical officers on the inactive reserve list.
2. Many medical officers had unpleasant personal experiences and there is no doubt that there were a certain number of medical officers and line officers of the regular service whose handling of the doctor from civilian life in Naval uniform was tactless, over-bearing and arrogant. I believe that this constitutes but a small percent of the service.
3. Older medical officers who had been successful in civilian practice found their income so sharply reduced while in the service that it was necessary for them to leave the service in order to rehabilitate their financial structure as soon as hostilities were over. Younger medical officers received greater pay than they could have expected in civilian life at the same period in their careers but the promises of future remuneration were so great that service pay was of no attraction to them. Even with the present increase of one hundred dollars a month more for medical officers the opportunities for obtaining a large income quickly in civilian practice is so great that the Navy pay offers little attraction to a medical officer.
4. Many young medical officers in the Reserve were ordered to duty at Recruiting Stations, Dispensaries, Training Stations, etc., where their actual medical work was at a low ebb. After medical school, internship, and residency the eager doctor desires to practice medicine on

RESTRICTED

RESTRICTED

the sick and injured. His introduction to service life consisted only of examining of recruits and care for minor illnesses.

5. It seems to me that there has been in the service a tendency to overemphasize the fact that a medical officer may obtain training to meet certification by a special board and a deemphasis of what a Naval medical officer should be. As one young medical officer said in trying to obtain medical officers for the service it seemed to him that there was too much emphasis placed on the fact that he could get out easily within four or five years if he wished and insufficient emphasis placed on the advantage of a career in Naval medicine.
6. Another factor which is hard for the Reserve medical officer to understand is the reason for running mates and the control of promotion by the running mate law. Many Reserve medical officers resented their "subordination" to line officers.
7. Lack of housing for Naval medical officers at all stations, was a vital factor in causing young officers to leave the service.*****

RECORDER

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert E. Simpson, USA (Ret.)
dated 1 May 1948)

***** "(1) The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel. Malassignment has been mentioned; also, stagnation and professional inactivity. But of greater importance, I believe, was the system of promotion - if it was a system. Promotion was not based upon merit and length of service, but depended upon whether or not a "position vacancy" existed. I have seen very capable, diligent young officers, assigned to a theatre in the grade of Captain, (Army) spend three years in the combat zone and eventually return to the zone of the interior for separation - still in the grade of Captain. These officers have seen, time and again, fellow officers of another branch of the service promoted rapidly. And sometimes there appeared to be a premium on inefficiency. It is true, and it is human nature, that if we have to release something, we are prone to give up that which we can spare best. When required to submit the names of the less diligent and energetic were submitted. These officers sooner or later would find themselves in a new command with many "position vacancies" - and be promoted! And the young squadron surgeon who did his work efficiently stayed on his job and in his grade, because he could not be spared. A Medical officer on duty with a combat unit would have to be recommended for promotion, not by his senior medical officer, but by the commander of the unit, who in a great many instances was not qualified to pass judgement on the physician's capabilities, and far too frequently, was his junior in age and certainly his intellectual inferior. This sort of thing embittered many, many, young medical officers. I remember one instance in particular: (I remember several as a matter of fact) the surgeon was originally commissioned as Captain, had two degrees, was a former instructor and member of hospital staff, F.A.C.S., and board diplomate, with a family, making payments on his home, etc. His commanding officer was ten years his junior, a Lieut. Col., a high school graduate only, and formerly a filling station attendant, who did not see fit to recommend the surgeon for promotion. Also, in many instances, the rank given the physician on his original commission was not commensurate with his ability. On one occasion, for example, a radiologist tried to enter service, but was not released or made available for the Armed Forces, because his services could not be spared (he was teaching in the Medical Department, University of Texas). At this time he could have been commissioned in the grade of Major (he was 38 and a diplomate of the American Board of Radiology). As time elapsed, a replacement was obtained for him as a teacher, and he was made available for military duty. But, he now was commissioned as 1st Lt. and, subsequently, assigned to an organization doing X-Ray work exclusively, but under the direction of one of his former students who by then had attained the grade of Major. Another cause of dissatisfaction was the rate of pay, which, of course, ties in with promotion. Many of the junior A.U.S. officers were actually indifferent as to the rank they held, but were hard put to take care of their

RESTRICTED

RESTRICTED

obligations; many had children in school, were making payments on homes, payments on their equipment, and, incidentally, paying storage and insurance on such equipment which was deteriorating and becoming obsolete. These officers were intimately associated with officers of other branches, who were younger, perhaps bachelors, were promoted rapidly and received flight pay - and, further, were granted leaves more often and had a shorter tour of duty in the combat zone. Needless to say, they felt this obvious discrimination keenly, and resented it, particularly, as they realized their fellow officers had been trained and qualified for their commissioned service wholly at government expense, while they had paid for several years training themselves, or were still indebted for it. *****

4. Since beginning this endorsement I have had occasion to discuss the subjects in basic communication with several young practitioners with whom I am in contact every day. These were formerly with the Army, Navy and Air Force during the recent war, and the majority had service overseas. As a general rule they are rather bitter, and "want no more of it", yet I am convinced each of them volunteered his services and made sacrifices willingly through motives of loyalty and patriotism, but too many of them feel as if their services were not utilized to the best advantage, and that in comparison with other branches were they treated unfairly."

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr M. C. Stayer, Major General, U. S. Army, Retired, 11 Apr 48)

****(1) The Chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel.

1. They were not used for professional work and were used as members of Boards of Inquiry, Investigation Boards and investigating officers other than which concerned medical or surgical problems.
2. Members of General and Special Courts Martial, which was considered wasting their and the government's time.
3. Filling administrative positions as executive officers for evacuation hospitals, convalescent hospitals, station hospitals, registrars, and adjutants for hospitals of the general hospital level.
4. Lack of promotion.
5. Commanding officers who were poorly selected and forgot they were still doctors."****

TRUE COPY EXTRACT

(Letter, Brig. Gen. Robert C.
McDonald, MC, USA (RET.)
dated 15 April 1948)

RECORDED

L. K. Pohl
L. K. POHL
Colonel, MC

**** "(1) Comment: Disaffection of medical personnel, particularly medical officers, results from:

"a - Misassignments: Too often medical officers are not assigned according to professional ability - too much administrative work is the complaint of many physicians;

"b - Too much purely military training, particularly for medical specialists;

"c - Lack of, or inequalities in, promotions;

"d - Idleness enforced by campaign conditions;

"e - Delay in demobilization." ****

RECORDED

L. K. Pohl
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Albert T. Walker, Captain, MC, USN, 26 April 1948)

*****The Chief points within the military structure contributing most to the disaffection of medical personnel were 1) inactivity, 2) improper assignment of medical officers, 3) inequalities in procurement which has been mentioned above, 4) the formation of so-called units which, when inevitably were dismembered, created a great deal of resentment among the Reserve officers of the various units, and 5) the use of two or more such separate units within a single command.

The first two objections can be mitigated to a great extent by the decentralization of personnel assignment so that the senior medical officer in the field can place men where best fitted. In the Seventh Fleet this worked out very satisfactorily when the Bureau ordered medical officers to the Seventh Fleet for assignment. The inequalities in procurement can be obviated by the inclusion of all doctors in any future mobilization plan with coordination of the whole by a Cabinet officer. I feel strongly that the Reserve unit is a mistake, that no attempt should be made to move such units in a body, and that the officers making assignments should be free to move personnel whenever and wherever the occasion demands. This again emphasizes the necessity for the decentralization of personnel assignment.*****

RECEIVED

L. K. POHL
Colonel, MC

TRUE EXTRACT COPY (Ltr Brig Gen Guy B. Denit, MC, Surgeon, dtd 13 Apr 48)

***** L. "The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel - One of the chief points was that the staff could not be impressed with the fact that it was and is essential that the Medical Department have more autonomy in running and administering its own affairs. It is believed essential that there be a branch allotment on a percentage basis for Medical Department personnel, officers and enlisted men and women; that there be a percentage of grades from general officers on down allotted to the Medical Department; that Medical Department T/O units be prepared in advance and approved by the Department for all eventualities and that these Medical Department units be placed under the command of the Sr. Medical Officer on each staff; that the Medical Department be exempted from personnel policies and procedures which establish bulk allotments for camps, stations, tactical organizations and theatres of operations.*****

RECEIVED
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Earl Maxwell, MC, Air Force
dated 19 April 1948)

**** "2. In general, the main complaint of the medical officers seen overseas was that they had been in various training units and replacement pools for long periods of time without having any duties. On checking their records it was often found that the individual doctor had actually been in the service for a year or more without having seen a patient. It is believed that this condition was much worse in the Army than in the Navy. In my opinion, the ordinary medical officer who is going to practice medicine or surgery in the military service needs very little training prior to actually going to a functioning unit. The Navy would send units overseas with the Commanding Officer and some of his administrative officers and a skeleton crew of enlisted men and the remaining medical officers, nurses and enlisted men would arrive after construction had taken place and the hospital was ready to operate. This seemed a definite saving in medical personnel. ****

***** "9. In the South Pacific one of the main causes of dissatisfaction among the medical officers was the fact that some had to be assigned to field units and they did not have an opportunity to practice medicine in a hospital. This was alleviated somewhat by giving post-graduate training courses in which the officers in tactical units would be sent to a hospital for training in their chosen subject for a period of 30 to 60 days and that the job was covered in the tactical unit by an officer from the hospital when it was necessary. This contributed much to the raising of the morale of officers assigned to tactical units."*****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. C. Greaves (MC) USN
dated 17 April 1948)

***** "I would like to emphasize that much of the criticism leveled against the medical services in World War II is the result of the wrong type of morale among medical department personnel. It did not affect medical personnel alone but was common throughout all branches of all services and all levels of civilian life. It was characterized by the wail that went up everywhere American forces were on duty after V-J Day, 'I want to go home'. There always seemed to me to be too much catering to the idea that the war effort must be made as painless as possible and not enough to building a hard core of good old fashioned military discipline of the type that forces a man to carry on when the pressure is off in the same manner as when he is under fire. A friend of mine once told me that he had spent six months training to spend six minutes blasting the enemy in a night battle in the Pacific. The war was of necessity like that. It takes discipline to win battles and wars and that discipline must be built up beforehand. It can just as well be of a nature that will continue after the shooting stops. If that sort of discipline and morale can be built up in the personnel of the Medical Services it will go a long way toward eliminating the disaffection which so many former members feel toward the services."

RECEIVED
L. K. Pohl

L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus, (MC) USN
dated 27 April 1948)

***** "(1) The Chief Points or circumstances within the military organizations which caused apparent disaffection among the medical personnel, especially officers, were disillusionment as to promises made prior to being ordered to active duty, frequent and sudden changes in duty without apparent reason from the individual standpoint, delayed action when ordered to overseas outfits and periods of duty when their services could not be fully utilized. A lack of understanding on the part of the individual that the situations causing his disaffection were perhaps inherently related to operational changes in prosecuting the war and therefore unavoidable when considered from the over-all viewpoint." *****

RECEIVED
L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 22 April 1948)

*****"(1) The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel. -- First, I think this was because medical officers were very often responsible to line officers and not to other medical officers. Secondly, I think so many times at least in the army the medical officers had nothing to do with the medical department and the medical department in turn had no authority over them. Thirdly, I think there isn't any question that many medical officers were badly wasted as to their talents and their efforts in the face of a terrific civilian need. Fourth, I think medical officers were very often used and given training which was entirely unnecessary. It never made sense to have medical officers run through the infiltration course and obstacle courses." *****

TRUE COPY EXTRACT (Ltr Capt E.P. Kunkel, MC, USN, dtd 21 Apr 48)

***** L. "It appears that, in general, some of the factors which are responsible for the dissatisfaction of medical officers in the Navy are: state of mind of people following a world war; lack of housing; lack of proper schooling for children; specialty boards; and last, but not least, remuneration in the service as compared to civilian positions."*****

RECORDED L.K. POHL

L. K. Pohl
L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Ltr Capt. H.R. Hering (MC) USN, Dtd 17 Dec 47)

***** L. "One of the greatest improvements that would accrue from the adoption of the above recommendations would be a raising of the morale of officers assigned to Amphibious Forces, especially in peace time. Marine Corps duty has never been looked upon as choice duty, primarily of course because of the little chance for clinical practice that it offers. If it was generally understood throughout the Medical Corps that duty with the Marine Corps offers the greatest opportunity for life-saving in time of war of any branch of the division which would assure adequate professional training for those in the field medical service, I am sure that we would have more enthusiastic regard for this type of duty."*****

RECORDED
L. K. Pohl
L.K. POHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT

(Letter, Captain O. B. Morrison, Jr., MC, USN
dated 23 April 1948)

***** "1. The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel.

After discussing this matter freely with a great number of medical officers, it is believed that the greatest cause for disaffection of medical personnel is lack of good professional work in the armed services. Admittedly, pay, retirement benefits and other such considerations, are important, but the desire to practice and become proficient in their profession by far outweighs any and all other considerations. There is a feeling that only a chosen few are allowed to work in good hospitals, while many are repeatedly assigned billets where little or no professional work is available. Much careful thought should be given to this matter so that many of the non-professional billets could be eliminated and in those which can not be eliminated, the medical personnel should be rotated as rapidly as possible. Thus recruiting duty, small dispensary and isolated station billets could be filled by a rotation of hospital personnel at short intervals." *****

RECORDER

L. K. Pohl
L. K. Pohl, Colonel, MC

TRUE COPY EXTRACT (Ltr Rear Adm F.L. Conklin (MC) USN, dtd 27 Apr 48)

***** L. "Gripes of many Reserve Medical Officers about not being able to follow their specialty during the war, I believe were not justified, as they were in their profession, while other professional men were not. Also many of us regular Medical Officers were taken out of our specialty and put in the administrative branch. I believe a general pool for the Reserve Medical Officers would be better than the Medical Divisions now being activated. Circumstances contributing much to the apparent disaffection were: 1) Inadequate indoctrination. 2) Varied periods of inactivity unavoidable in war, but not understood by the individual. 3) Keeping up expensive insurance policies and home expenses on a much smaller income. 4) Not being assigned to their specialty. *****

L. K. Pohl
L. K. POHL, Colonel, MC

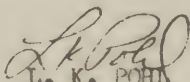
RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Rascom L. Wilson, Colonel, MC, Air Forces, 21 April 1948)

*****Reference par 3(1) "The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel," it appeared that the chief points or circumstances contributing to the apparent disaffection of medical personnel, (officer personnel) were as follows: (a) Mal-assignment, (b) haphazard methods and inequalities in the promotion system, (c) lack of a planned, definite or fairly flexible system for overseas assignment of medical personnel, and (d) the system of release after cessation of hostilities.*****

*****"In regard to the promotion system for Medical and Dental Officers as many or probably more complaints were heard on this subject than any other. Among the young officers, those just out of Medical School, or those with only a few years of experience and without any specialty, the complaints appeared to be unfounded as most of these received Captaincies at least, during their service, which seemed sufficient. However, many of these young Medical Officers found their way into Headquarters Staff Sections and ultimately, received promotions far beyond that which would normally be expected, while numerous Medical Officers, particularly in the Station and General Hospitals, received very few promotions due to lack of available vacancies. It was quite common to see Medical Officers of outstanding ability and well known in their communities, go thru their whole service as Captains, while maybe on their own station, they would see young Air Force Officers, of comparatively few year service, serving in the grades of Lt Colonel, and even Colonels. No disparagement is meant to these young Air Force Officers, however. It is true that later on, after cessation of hostilities, Medical Officers as well as all others, received a one grade promotion on their release from the service if they had been in-grade for a sufficient length of time. However, this did not make up for the apparent lack of interest on the part of higher authority and the lack of plans for some sort of equable promotion system for Medical Officers and Dental officers commensurate with their capabilities, experience and standing in civilian life. The promotion of skilled specialists in the Medical and Dental Corps should be made to grades commensurate with their value to the service regardless of vacancies. Age and experience should be considered."*****


L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain Emmett D. Hightower (MC), U. S. Navy dated 21 April 1948)

----- "(1) A few circumstances and factors which were noted to contribute to the apparent disaffection of medical personnel, particularly Reserve Officers in World War II, are as follows:

"(1) Too frequent changes of duty. For example, one Medical Reserve Officer was shifted ten times within a year in the continental United States.

"(2) Lack of utilization of specialized training.

"(3) Lack of something to do. Doctors in replacement pools were frequently retained for months with no opportunity of doing medical work whatsoever.

"(4) Frequently officers received immediate detachment orders only to arrive at their new station and learn that the activity would not be in commission for several months, whereas they had been badly needed in their previous assignment.

"(5) Shortage of medical officers at certain activities and an excess at nearby activities; i.e., one hospital was known to have one Psychiatrist to care for over 400 cases while another hospital in the area had four to five Psychiatrists with very few patients to care for. This of course, was the fault of the command who failed to call the deficiency to the attention of the Detail Office.

"(6) Irregularities of rank.

"(7) Difficulties encountered in reporting to a new station of duty: It was not uncommon during the war to encounter a medical officer who had been looking for the ship he was supposed to report to for as long as four months-----

----- "As far as I am able to ascertain, and from personal observation, medical services furnished during World War II were outstanding. The health standards of troops and the survivor rate among the wounded were unequalled in the history of warfare. I believe that most of the criticism directed toward the medical service emanated from disgruntled Reserve Officers. This will occur in future emergencies, because it is not possible to please everyone in time of war. However, efforts should be made to eliminate deficiencies in personnel management and assignment. This should apply to the Regular Officers as well as to the Reserve Officers." -----

L. K. Pohl


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTEDTEXT COPY EXTRACT (Letter, T. F. Cooper, USN dated 19 April 1948)

***** "Much criticism has been leveled at certain aspects of the policies relating to mobilization, utilization and demobilization of medical resources incident to the last war. Some of that criticism was born of individual self-interest and a disregard for basic military principles. Other was based on misinformation or misunderstanding. Some was and is most certainly justifiable." *****

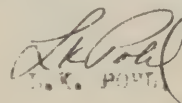
***** "Points that have given rise to disaffection among medical personnel are many. War is unpopular and on termination of hostilities there is a tendency to separate one's self quickly and completely from any service connection. Differential between service pay and pecuniary rewards in civil practice is too great. Sea duty and duty at small stations, recruiting duty, etc., are not appealing to the great majority of medical men. Ideas of peacetime service are often based on experience during war service wherein long periods of separation from family and friends, often in remote areas with only trivial medical duties, obtained. Increase in educational requirements and costs of obtaining same are deterrents to service interest. Service interns, if given a regular commission on completion of internship, should be given full credit for longevity and pay purposes for the time spent as an intern." *****



L. K. Pohl, Colonel, MC

TEXT EXTRACT COPY (Ltr Col. Robert P. Williams, MC, Surgeon, 18 Apr 48)

***** L. "The chief points or circumstances within the military structure contributing most of the apparent disaffection of medical personnel. This subject may be discussed interminably. The universal draft, with assignment of every individual to military or civil posts in accordance with the requirements, would cure most of these ills. Also it is believed that it is draft would increase the feeling that everyone is serving, decrease the present selfish attitude."*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Quinton N. Sanger, BUMED, USN, 7 April 1948)

*****The following preliminary material on subject is submitted for information. This material is based on criticisms of the Medical Department voiced by medical officers attached to the Navy during the War, and by Reserve Officers who directed their complaints to Congress. Official comment within BUMED on the various criticisms made varied considerably all the way from outright disapproval to limited agreement.

The complaint was made that after the medical officer's trained in clinical duties, and is at the height of his abilities as a Captain, he is diverted to administrative duties. In April 1946, 71 out of 112 members of the Medical Corps certified by various specialty boards were in administrative positions.

Doctors serving in the wartime Navy complained in letters to Congress that they were unable to practice satisfactorily the profession of medicine in the Naval Service. * * * Many billets were deemed undesirable by the doctors because of the professional sterility of many of the wartime (and peacetime) duties. This opinion was substantiated by the letters to Congress and by a preliminary analysis of the billets filled.

It was held that to attract doctors to the Navy they must be assured reasonably absorbing professional responsibilities and duties, professional post graduate training, rotation on necessarily dull duties, and an opportunity to demonstrate and develop individual professional interests.

It was suggested that professional promotion procedures were inadequate. It was proposed that there be established a maximum number for each grade in the medical Corps, and that such promotions should be independent of line percentages. CNO felt this proposal would nullify the beneficial effects of the "Line Staff Equalization Act of 1926" and would precipitate many of the same inequalities this law was enacted to correct.

Many reserve medical officers were disgruntled about their assignments or duties during the war. It was proposed the vagaries of war be explained to the reserves - for example, why casualties were overestimated, why medical officer distribution was poor in certain areas, etc.

CNO asserted that doctors were idle at coastal stations or Pacific bases because of temporary postponement of or changes in contemplated operations.

'Moreover, the building of medical facilities and medical personnel in the Pacific during the last few months of the war (which were not used) were (six) necessary in preparation for the expected costly assaults on and invasion of the home island.' CNO believed the average intelligent reserve officer already had an understanding of these vagaries of war.'*****

RECEIVED
L K POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACTS

from Report to Committee on National Emergency Medical Service dated JUNE 4, 1947, in an Analysis of the Replies to the Post War Questionnaire as prepared by the American Medical Association, sent and received by 49,457 former medical officers of the Armed Services.

***** "Possibly the most important summary statement is to repeat that 55 per cent, more than 26,000 of the former medical officers contacted replied to the lengthy questionnaire. This amazing response came from 20,001 army doctors, 5,727 former navy doctors and 290 replies from United States Public Health Service or Veterans Administration doctors or from combinations of the four during World War II." *****

***** "Comparisons between army and navy doctors revealed that the average army doctor served forty-two months as against thirty-six months for the average navy doctor. A smaller percentage of navy doctors, 11, were general practitioners before entering military service than army doctors, 17." *****

***** "The replying navy doctors slightly outranked the replying army doctors, and slightly more of them spent their entire or longest period of service in North America. A larger percentage (60) Army than Navy spent more time in hospitals than in dispensaries and other types of service. Navy doctors were more idle than army doctors only because they were busy on 71 per cent of their time, gaged by civilian standards, of which 51 per cent was in the performance of professional duties and 20 per cent in the performance of nonprofessional duties. These percentages for army doctors were 50 and 30 respectively. Also during noncombat periods navy doctors were more idle than army doctors, with 40 per cent professional plus 16 per cent nonprofessional, whereas army doctors were busy 62 per cent of their time, 39 per cent professional plus 23 per cent nonprofessional. They were asked to estimate the number of doctors actually needed in their units; Army replies averaged 72 per cent and Navy replies 70 per cent, reflecting consideration of "peak load" requirements. The general conclusion of the survey is that considerably more doctors were inducted into the armed services than were needed in the opinion of the doctors themselves, although some question may be raised concerning the competence of humble doctors in the ranks to measure military necessity as to both time and nonprofessional duties. Replies from so many doctors give weight to these criticisms - the wastage of medical skills." *****

***** "Both army and navy doctors agreed that "professional on-the-job" training was the most useful feature of their training, and that an ideal training program should stress more medical training, both general and in the specialized fields of military medicine. Neither army nor navy doctors were enthusiastic about their assignments, although navy doctors were slightly better satisfied. Forty-eight per cent of the

RESTRICTED

RESTRICTED

TRUE COPY EXTRACTS from Report to Committee on National Emergency Medical Service dated June 4, 1947, in an analysis of the Replies to the Post War Questionnaire as prepared by the American Medical Association, sent and received by 49, 457 former medical officers of the Armed Services, continued:

Navy doctors reported that they were rotated in assignment, and only 22 per cent Army doctors." *****

***** "A question relating to how medical personnel could have been used more effectively if it was wasted in his unit brought replies which stressed better assignments, reduction in the number of doctors and fewer nonmedical duties, the latter being stressed more by army than by navy doctors. Suggestions regarding assignment of medical officers in the event of another national emergency revealed that more consideration of age and qualifications, assignment according to actual need, rotation of duties, and rank and promotion according to professional ability were the most popular remedies. In rating efforts to utilize their professional skills, the replies indicate that the doctors thought these efforts only moderately successful, even less for Army than for Navy. The replies indicated reasonable success in getting medical publications to the doctors, although, of course, navy doctors had less trouble with transportation and received the journals more regularly. Army doctors reported more teaching clinics and more medical meetings in their theaters than navy doctors. Replies from both indicated that the most popular suggestions for helping the doctor in service keep up professionally were assignments better fitted to professional skills, prompt receipt of latest literature and hospital assignments."*****

***** "What These Doctors Want. The Committee has asked me to state what I think the 26,000 replying former medical officers want as well as what the typical civilian practitioner wants in the event of another national emergency. These interpretations are my own but I shall studiously refrain from expressing personal opinions about the issues involved and only try to state clearly what the doctors have been trying to tell us by means of these two surveys. What they want may not be timely, wise, expedient or feasible." *****

***** "What the doctors want is neither mean nor petty nor vindictive nor backward looking. They clearly recognize that war is hell and war is waste. What they want must surely be a bold, courageous, forward-looking program and not one which looks backward toward the last war. They want a public spirited organization, representing the profession, established and implemented in the hope that it can help to prevent the mistakes of World War II. They want the limited supply of medical skills carefully and wisely distributed as to attain the highest standards of medical care for civilians and military personnel in the event of another national emergency. They doubt that 60 per cent of the nation's physicians could provide effective medical care for the civilian population in the event of an atomic war although that proportion was (miraculously) evidently sufficient during World War II. In the second place, the former medical officer wants the highest officials in Washington to ask the Secretary of War and Secretary of Navy to review their organizational tables and pre-

RESTRICTED

RESTRICTED

TRUE COPY EXTRACTS from Report to Committee on National Emergency Medical Service dated June 4, 1947, in an analysis of the Replies to the Post War Questionnaire as prepared by the American Medical Association, sent and received by 49,457 former medical officers of the Armed Services, continued:

cedures in order to prevent a recurrence of (1) the medical overstaffing of units, (2) wasting of the time of doctors of medicine in the performance of nonprofessional duties which could have been performed effectively by nonmedical personnel, (3) removal of a needlessly excessive number of doctors of medicine from civilian hospitals and practices, (4) the rather widespread failure to make assignment and provide for rotation of doctors of medicine on the basis of their professional skills and qualifications, experience and age, (5) a military hospital construction policy which will give close attention to possible civilian wartime requirements." *****

RECORDED

L.K. Pohl
L.K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY (Ltr Dr. H. S. HOFFMAN, Dtd 13 May 48)

***** L. "In general, officer dissatisfaction was blamed most frequently on the following items: 1. Inequities in recruitment rank of reserves. 2. Apparent inequities in promotions as between regulars and reserves. 3. Apparent inequities in recognition of outstanding services as between regulars and reserves. 4. Failure of regulars to appreciate training, experience background and ability of reserve officers. 5. Apparent unnecessary changes of duty. 6. Hurry-up to stand-by orders. Many reserve officers received orders to report immediately to stations and on arrival found that there was nothing for them to do for weeks. 7. Assignment to stations distant from homes on return from duty outside continental limits. 8. Incompetence of individual senior officers. 9. Failure of Medical Department to fulfill recruitment promises as to assignments. 10. Failure to receive duty and stations for which preference was repeatedly expressed in fitness reports. 11. Difference in official action as between Regular and Reserve in the matter of separation for disability. 12. Apparent clanishness on the part of the Regular officers and their families toward the families of Reserve officers. 13. Impatience of Reserve officers with the necessity of doing administrative and paper work.

Keeping in mind that reference is made to the Navy Medical Corps only, it was noted that there was little disaffection as between officers and enlisted personnel; that officers were more articulate concerning dissatisfactions than enlisted personnel; that officer "griping" resulted in the main from two factors: (1) Inadequacies of individual superior officers (medical) - not Regular Officer relationships - to be discussed later. Improved officer and enlisted personnel relationships was a source of considerable satisfaction. The improvement as over conditions noted in World War I was quite marked.

General Comments - Thoughtful review of my entire experience (within the continental limits and in the Pacific Theater) led to the formulation of the following definitive ideas:

1. The medical operations and accomplishments of our Armed Forces in World War II is one of the great stories of the war - as yet untold. With huge numbers of troops subjected to difficult weather conditions, unusually perplexing diseases and the devastating effects of high explosives plus extensive burns, the percentage of recoveries was incredibly high.

2. Deficiencies and failures of individual officers - particularly senior officers of the regular corps - were minimal. There were due in the main to the practice of recalling to active duty previously retired officers at grades substantially higher than their retired ranks. This was adequately offset by the work of the rest of the corps - pitifully small shortly before the beginning of hostilities. It takes a little thinking to recall examples of poor officers. On the other hand, examples of fine, capable officers come to mind very readily.

3. A great many - if not the majority - of the complaints and criticisms come from junior officers who were consequently not in a position to understand the necessities for certain operations or methods of procedure. Therefore, dissatisfactions from this group must be heavily discounted.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Ltr DR. H. S. HOFFMAN, DTD 13 May 48, CONTINUED)

Reserve and Regular Officer relationships: There is much to be said on both sides. In fact, already too much has been said without constructive suggestions as to possible corrective measures. In the light of the superlative over all accomplishments of the Medical Departments of the Armed Forces it is difficult to be too critical. On the other hand, the violence of the negative reaction on the part of the Reserve Officers to the suggestions that they remain in the Services after the war, cannot be without some basis in fact. Actually, I believe that the chief source of disaffections in the medical corps stem directly or indirectly from the inadequacies of this relationship. It would be a rather sterile procedure to discuss at length such items as inequities in recruiting rank, promotions, recognition of outstanding services, etc., inasmuch as the records of the department are available for the determination of the actual facts. Other items in the bill of complaints also lend themselves to evaluation by study and analysis of the existing records. Further elaboration, therefore, would serve no useful purpose.*****

L.K. Porel
L.K. POREL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - APTAS.

***** L. "Medical Corps Officers. Passing from morale problems of aircrew and ground force personnel to those involving the medical personnel; it appears that concern on the part of medical officers with duties not customarily within the scope of their previous training or experience, constant routine, and dissatisfaction with rank produced morale considerations of no small moment to medical administrative authorities. In the first place, the rank held by any given medical officer or group of officers was, in general, below that of line officers whose assigned tasks required no more training or experience and involved no higher degree of responsibility than that required of the former in the execution of their duties. The discrimination lowered the morale of medical officers and placed an obstacle in the path of their efficiency.

Air Force medical personnel see ever changing groups of flying personnel constantly coming and going and rising in rank with a rapid speed. The medical people, who are under-ranked to begin with, soon have removed that incentive to combined effort which aspiration to higher rank supplies. This fact, coupled with the absence of definitive medical activity, continued long absence from home, and the placing of too much stock in unfounded optimistic rumors, all are responsible for the lowered morale and efficiency.

Medical Department Enlisted Men. Just as in the case of medical officer personnel, the morale of the medical enlisted men was adversely affected by discriminations in the matter of rank. It was recognized in February 1943 that the provisions made in the original Table of Organization, Allotments and Grades for Medical Enlisted Men, were "grossly inadequate" for the men filling the various responsible positions assigned to them. More than a year later the greatest dispensary problem in the First Bombardment Division was "that of recognizing the good work by some of the enlisted personnel in the Station Complement Squadron."

Despite these admonitions the ratings and ranks of medical enlisted personnel were not altered and remained unsatisfactory after the changes in the T/O in Sept 1944, which allotted the majority of the medical enlisted personnel to the bomber group headquarters and left only five each to the squadrons. Apparently no official action was taken to ameliorate or rectify the situation.*****


L.K. FOHL, Colonel, MC

RESTRICTED

RESTRICTED

Extract of Statements made by Brig Gen Robert C. McDonald, MC, USA (Retired), 21 April 1948, before the Subcommittee on the Employment of Military Medical Resources.

****"The next subject, "The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel."

I saw a considerable lot of dissatisfaction among the medical officers, particularly the reserve, and they were due first to malassignments. "Too often medical officers are not assigned according to professional ability - too much administrative work is the complaint of many physicians."

On the other hand, occasional errors were made in the assigning of men who said they had the qualifications and who actually didn't have them. All these complaints were not legitimate. Men who are qualified to do high-grade professional work should be put on that.

I recall during the first world war, just before the Battle of Saint-Mihiel, I was on duty at the medical school over there in France, and the Chief Surgeon sent down and wanted to send everybody up to the front who thought he could take charge of an operating team, or be first assistant. I had about 60 or 70 medical officers, a great many of whom thought they were qualified until the time came. I announced to them that we would send up to the front all those who were capable and qualified to do the work and I didn't want anybody to volunteer for that work and then go up there and fall down on it, because it certainly would be shown up, and I think I got three out of the whole bunch. One of them would take a team, only one, and the others were assistants.

So we do have to check up on the qualifications of medical officers to determine exactly what they shall do in order that they may be properly assigned.

The second reason is: "Too much purely military training, particularly for medical specialists."

Take a brain surgeon, or any sort of medical specialist who is not going to do anything except that work. He doesn't want to do anything else. He can't do anything else, and to give him a lot of basic military training I think is unnecessary. That should be reduced to a minimum. There probably should be some, but not enough to ruin his morale or take him away from his work very long.

"Lack of, or inequalities in, promotions;" I think I heard more kicking about that than any other one thing. Everybody wanted promotions, of course, it's only human nature that they should.

We had great difficulty in getting lieutenants promoted up to the grade of captain. In my service command we had hundreds of lieutenants who had been in the service a considerable time, maybe more than what was required, say one year for promotion--or six months at one time it was, but we couldn't get them promoted. The policy had been approved by the War Department, but it had not

RESTRICTED

RESTRICTED

been implemented. It was all right. General Somervell said, "Yes, give them promotions," but didn't tell the Service Commands or anybody else just how it should be done, and you couldn't get it done. There was a long time after General Kirk got that policy over before he could ever get those promotions for those lieutenants, and it hurt their morale pretty badly. It did finally get worked out all right.

I don't think that anyone in the War Department was particularly to blame for it. I don't know why it was held up, I can't imagine, but it was, and General Kirk didn't seem to be able to jar it loose and of course we couldn't do anything down in the next echelon.

The next criticism the medical officers particularly have is the "Idleness enforced by campaign conditions;" In England, when they were waiting, getting ready for that attack on France, nobody knew when it was coming or whether it was coming or not; there was a lot of idleness over there that couldn't be helped. I don't think you can do away with all that, but we certainly shouldn't have any more medical officers than we need, because we have got to have a proper quota in civil life, or at least a reasonable quota, but that was one kick about not having anything to do; not all that was legitimate, either, because some of them could have found work, I presume, if they ~~tried~~ ^{tried} hard enough.

The last criticism is the "Delay in demobilization."

The prominent medical officers who had been carrying on in a splendid way felt that they had carried out their patriotic duty and wanted to get out as soon as the armistice came and they were dissatisfied if they couldn't get out. And a great many of them did get out and others were held in; but we did have a great many junior consultants and specialists in the later stages of the demobilization.

Brig Gen McDonald: "Should we promote medical officers in the Reserve based on professional advancement during peace, or should the old system of unit vacancies and military duty in the Reserve be the basis?"

Many times in this last war I know of some instances where a highly-trained specialist would come into the Army late, perhaps having been retained in civil life through no fault of his own, and find himself under the supervision of a higher-ranking medical officer who had very little special training. I believe that promotion should be based largely on special qualifications, particularly on professional qualifications.

I think that rank in World War I and II was given in many instances simply for reimbursement for special qualifications. The man got more pay, and in that way I think it was proper. There should be some way of paying a specialist adequately for his work. I think it was reasonable, that is, the rank for the dental and veterinary people.

"Should American Specialty Board membership be the sole index to the recognition of specialists? If not, would you suggest a basis for decision in this field by the Surgeon General's Office?"

RESTRICTED

RESTRICTED

"Will more autonomy of the Surgeon Generals and consequent release of medical officer control from G-1 and BuPers provide an opportunity for improvement in assignments, etc.?"

Yes.

"Has the commissioning of nurses and other females in WSC and WAC added to the disaffection of medical officers? What is a practical solution to this aspect of the problem?"

I don't believe that medical officers as a rule were dissatisfied with giving rank to women that worked in the hospital.

"Should pay of doctors be increased to comparable civilian levels? In time of mobilization aren't all grades denied compensation for their real efforts?"

I don't think we should try to have a doctor earn as much in the service as he does outside, any more than an engineer should earn more, or anyone else.

Obviously much idleness of doctors is caused by their call into service long in advance of professional need for them. What scheme would you advise to replace that used in World War II? Could the "alert" system as used in World War II be improved? If so, how?"

I have answered that, saying proper planning and timely classification.

"Will the present emphasis of replacing medical officers by delayment in key administrative positions further increase disaffection in medical officers by depriving them of promotion opportunities?"

I don't think so.

"Should the armed service medical departments participate in planning for civil emergency defense? If so, on what level?"

Yes, I think they should. It should be on the territorial level, I think.

"Would opening of training facilities in armed service hospitals for selected civilians be advisable to engender better mutual understanding of our problems?"

Yes, I think that would be of advantage.

"What is your opinion as to the advisability of including the Veterans Administration in armed forces planning for procurement of medical personnel, etc.? Public Health Service?"

I think that if you have the registry you would have your whole plan. I believe there should be coordination on the needs of all Federal medical services in the procurement of personnel.

"Do you favor the ASTP system of producing medical officers in war? If not, why?"

RESTRICTED

RESTRICTED

Yes, I favor it. But I favor making them serve five years instead of two, after they are through with that training. Two years is too little. They get two months off out of the 24 so they serve 22 months. You get that man for 22 months, and the Government has perhaps paid his way for four years. I certainly think five years would be a better standard; and I believe we could get them on that basis.

"Do you favor subsidizing in any way medical students during war? Why?"

That's the ASTP system.

Brig Gen Martin: Not in its entirety. You could change it to an outright subsidization. That is a moot question now. Some people are not advising only inwar, but in peace, a complete subsidization of a medical student, even a pre-medical student.

Brig Gen McDonald: I don't believe in it. I do believe in ASTP.

Q By giving medical students a commission as a second lieutenant in the MSC Reserve they were exempt from Selective Service calls. Do you favor a return to that system?"

I don't favor a return to that system.

"Did you favor bringing ASTP's in to the service after the war to relieve reserve medical officers earlier from the service? If not, what should have been done to prevent disaffection in reserve officers?"

I believe in bringing them into the service after the war. I believe they should serve at any time after they complete their training. They should give the prescribed length of service to the armed services, whether it is in peace or war.

"In your experience, is there a need for an armed forces medical intelligence agency to establish and maintain on a current basis worldwide medical information that is so essential to planners for global war? If so, what organization seems most practical?"

I think it is necessary that we have armed forces medical intelligence agents.

Brig Gen Martin: Could that be part of the proposed medical section of the Joint Chiefs of Staff?

Brig Gen McDonald: I think so.

"Should our medical service provide a section for each of the specialties to prevent disaffection in groups? (Sanitary engineers, biochemists, etc.)"

No, too many corps and divisions.

"Do you favor placing a civilian representative of medicine on the staffs of superior headquarters surgeons during war? If not, why?"

RESTRICTED

RESTRICTED

I do not favor it. I want my consultant commission in part of my office."*****

L. K. POHL
L. K. POHL
Colonel, MG

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY (Extract of statements made by Colonel Thomas J.
Hartford, MC, USA on 23 April 48 at interview
with Subcommittee on the Employment of Military
Medical Resources)

***** "1. I would like to preface (L) there, by stating that
in my opinion the dissatisfaction in the medical service was not any
worse than it was in every other element of the armed forces; that
we should do everything we can to minimize the complaints, but that
we must realize there will be complaints regardless of anything we do.****



L. K. Pohl
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain W. D. Small (MC), U. S. Navy
dated 5 May 1948)

***** #12. (a). Poor leadership.

(b). Placing of unsuitable, incompetent or disinterested officers in positions of responsibility.

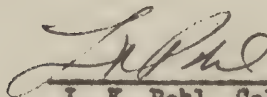
(c). Unwillingness on the part of many senior officers to respect the ability of reserve personnel, to appreciate their difficulties and to take the trouble to give them constructive aid when needed.

(d). Indecision and vacillation by high commands.

(e). Too much control by line military commanders over strictly medical functions.

(f). Grossly inadequate quantity of government quarters particularly for junior officers and married enlisted personnel.

(g). Too much "decision by expediency" as contrasted with honest and frank evaluation followed by forthright action."



L. R. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TABLE 1 - SUMMARY: (Ltr LtCol W.J. Meuter, Dental Corps, Dtd 11 May 48)

***** L. "Authorization of Grades for Dental Personnel: a. Efficiency - Of the grades authorized dental officers there were too few in the field at times. The Far East Air Force in April 1945 was authorized 4 Majors and eight, -four Capt. In June 1945 62 Captains were added to this number. The Eighth Airforce in July 1944 was authorized one Lieutenant Colonel, five Majors and 195 Captains. Enlisted personnel were authorized a maximum grade of corporal. Authorizations of grade in other AirForces were similar.

b. Unfavorable Effects - Officer personnel with highly specialized training were stunted in the grade of Captain regardless of their maturity, diligence, attention to duty and technical skill. Enlisted personnel were stunted in the grade of corporal. In the case of both officers and enlisted men the morale and efficiency suffered materially. While the officers had no means of escape, enlisted men often were lost to the dental service for this reason alone after much time had been spent to train them for their duty.

c. Recommendations - That grades be provided dental officers in the same proportion as officers in other services, and that enlisted dental assistants be authorized in the grade of sergeant.*****

John J. Meuter
L.J. Meuter, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Ltr Capt. M.S. Mathis (MC) USE, Ltr Dtd 6 May 48)

***** L. "Frequent changes in assignment of duties which appeared to the individual to be unnecessary. Specialist being required to do professional duties other than their specialty. Medical Officers in pools in the Pearl Harbor area felt that their time was wasted when unemployed. This was partially alleviated by temporarily assigning them to duty in hospitals where they were able to do some professional work."*****

L.R. POHL
L.R. POHL, Colonel, MC

TRUE EXTRACT COPY (Ltr Brig. Gen. C.R. KEMMERBECK, Dental Corps, dtd 7 May 48)

***** L. "The following were the main causes for dissatisfaction by dental personnel on Air Force duty during World War II. 1) Probably the most important single factor was the dental care given to individuals other than those in the military service. Dental officers felt that dependents and others not in the service who received dental service was securing it at the expense of service personnel. Regulations authorized this when practicable but this had many interpretations and was usually decided at station level by other than Medical Department personnel. In the future, these individuals should either be authorized treatment definitely and personnel furnished to accomplish it or it should be limited to the emergency treatment of pain only. 2) Too frequent transfers to other stations for no apparent reason. 3) Dental officers kept on the routine of inserting amalgam and silicate fillings were not given the opportunity for experience in exodontia, oral surgery, periodontia, prosthesis and crown and bridge work. 4) The impossibility of finding living quarters in the vicinity of military stations. 5) Serving under officers of the Medical Corps. 6) Poor promotions as compared to officers of other branches. 7). Regimentation of Army life and not being their own boss. 8) No chance to be promoted due to Table of Organization limitation as to rank. 9) Low pay scale as compared with earnings in civil life. 10) Some stations emphasis are on a definite production on a quota system rather than stressing quality of service. 11) Frequent loss by transfer of trained enlisted and civilian assistants. 12) Specialization training impossible. 13) Army red tape and class consciousness. 14) Domination of the Dental Corps by the Medical Corps. 15) Service politics. 16) Two dental officers per thousand were not enough to do the job required in World War II. It should at least be three per thousand in the future emergency. 17) Prosthetic dental service as supplied by Central Dental Laboratories was much below the standard of most civilian dental laboratories. 18) Too much record keeping and duplication of dental forms for each individual in the service."*****

L.R. POHL
L.R. POHL, Colonel, MC

RESTRICTED

RESTRICTED

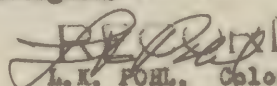
TRUE EXPL. COPY OF MEDICAL SUPPORT OF THE USAAF IN THE MEDITERRANEAN THEATER
HISTORICAL SECTION - AFTAS

***** L. "Another circumstance that caused dissatisfaction in many instances among both officers and enlisted men of the Medical Department was the meagerness of opportunities for promotion. The chief obstacles in this respect appear to have been Table of Organization restrictions and the policy of sending replacements in grade from the Zone of the Interior.

A similar situation with respect to the squadron medical sections of an Air Depot Group existed over an extended period of time.

Generally speaking, the morale of Medical Department officers and enlisted men was relatively higher during their first year of foreign service than afterwards. Although probably the most universal depressants to morale were rotation and promotion policies, mentioned above, other factors contributed in some instances to dissatisfaction within the medical section of a particular organization. Among these causes of a lowering of morale were insufficient occupation.

On the whole, medical officers found themselves occupied with routine matters in which they had little interest professionally, while dental officers for the most part were engaged in work more nearly in keeping with what they had done in private practice, though, to be sure, they were often overworked and had inadequate equipment. However, the feeling among dental officers and enlisted men that they were being discriminated against with respect to promotion and to rank and ratings fixed by Tables of Organization probably outweighed the above-mentioned considerations. In the Twelfth Air Force it was thought that flight surgeons who were intensely interested in aviation medicine showed the least loss of morale; but that a few medical officers who had attended the School of Aviation Medicine, apparently against their wishes, tended to lower the morale of the organization to which they were assigned.*****

 DER
L.K. FOHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 Apr 48.

***** L. "The status of our nurses changed three times during the last war, which resulted in changes in promotion policy. It wasn't until officer status was granted that more stable promotion policies were made and position vacancies authorized. Interference in matters of promotion and assignment by personnel, nurse personnel, was made by personnel in higher echelons on the basis of personalities and personal friendships, rather than on professional requirements and needs. While this was not on a large scale, it happened in more than isolated cases.

In general, the housing situation of the women in the Medical Department of the Army does not compare favorably with the women of the Navy and may, unless there is some equalization, be a detriment to future procurement. I think every effort should be made to allow women to have adequate and home-like quarters — I'd say bachelor officers — for both men and women where they may entertain their friends and not feel that they have nothing but a public living room. I think fully-furnished quarters are desirable, and we think that such accommodations would result not only in smoother operation, but in economy of operation and better morale. We had good quarters during peacetime. We were on a different status. We were provided quarters fully maintained and furnished as part of our pay. Many of these quarters are still in good condition. The quarters, of course, that were necessarily constructed during the war were not the type that we had been given prior to the war, and the furnishings were of a cheaper nature, and of course, didn't stand up. But it has been brought to my attention more forcibly than ever on these trips that we have been taking with the joint groups of the Army, Navy, and Air Force that the Army and Air Force nurses are not as well taken care of in the matters of housing as the Navy. The Navy quarters are fully maintained and fully furnished.

I think, maybe, that's about all I have.

As I say, there shouldn't be any difference, I don't think, in operational policies for women officers of the armed services — Army, Navy or Air Force.

BRIGADIER GENERAL MARTIN: Was there much disaffection among nursing personnel during the war because of the care of dependents?

COLONEL PHILLIPS: I don't think so. We had nurses who objected to the care of women and children. They said they came into the service to take care of soldiers. But the number was not great. We still occasionally find somebody who makes such a remark, but I think we are educating them to the fact that we want women and children in the hospital; we want to be able to take care of them because of the types of services. I think the number was not any greater than you would find with any group. You always find certain nurses who prefer to take care of male patients rather than female patients.

BRIGADIER GENERAL MARTIN: You mentioned the use of nurses in the transport of war brides and so forth. Do you consider the presence of a nurse necessary to the extent that nurses are or have been used for such jobs which are largely chaperon in nature?

COLONEL PHILLIPS: No. I think we could reduce the number for such jobs.

RESTRICTED

RESTRICTED

1

TRUE EXTRA COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANO, 28 Apr 48, Cont.

BRIGADIER GENERAL MARTIN: Could not WAGs or other women?

COLONEL PHILLIPS: Yes. I think the WAGs could help, but one of the difficulties -- and I am speaking very frankly -- in the first programs of transporting those people was the fact that many jobs in the care of children that should have been handled by the mothers themselves were delegated to the nurses and WAGs. I know the WAG Headquarters objected to it, and so did we. We felt that those people should have been oriented, told what to expect, and be given the responsibility for the care of their children, not have the children just taken away and put in the care of professional personnel.

Now, certainly I think they need nurses on those transports. The children get sick. The mothers need some assistance and education in the matter of preparing formulas, feeding, etc. The standards of some of those people are not as high as American standards. Then, too, they did not have the advantages, living in those war-torn countries. I think that nurses had an opportunity to help those people, but I feel they could have gotten along with less nursing personnel than they did. I feel the need for a greater number of nursing personnel is in the hospitals where our patients are.

BRIGADIER GENERAL MARTIN: Do you believe now, that the Nurse Corps has reached an officer status, that the purely menial work, such as you have described, should be a duty of the officer nurse?

COLONEL PHILLIPS: I think that no job which contributes to the comfort and welfare of a patient is menial, and I wouldn't hesitate to do any of it.

BRIGADIER GENERAL MARTIN: I am speaking now of the care of war brides and things you have just described.

COLONEL PHILLIPS: I don't think it is menial. I don't think it is necessary for a professional person to do some of the duties that they needed to do.

BRIGADIER GENERAL MARTIN: What suggestion do you have that would tend to prevent or minimize the most common complaints -- idleness, misassignment, regimentation, favoritism, lack of rotation, non-professional assignment, injustices in promotion, etc.?

COLONEL PHILLIPS: Well, first of all, orientation for all our personnel. In matters of promotion, I think that the Medical Department or the Surgeon General's Office should be the one to decide whether or not people meet the professional requirements for promotion. I certainly think they should have something to say as to whether the people will or will not be promoted. For malassignment, I don't think that we could be justly accused for much malassignment or whether many of the nurses can say a large number of them were malassigned who, first of all, were nurses. We may have had a little additional training or postgraduate courses in certain specialties, but we have all had basic training as nurses, and I wouldn't consider myself malassigned if I were doing bedside nursing. As to the distribution of nurses, I don't know, in an overseas area, now, during war, that could be too well handled; but, as I said in my remarks before, in the zone of interior, if the Surgeon General's Office could make transfers or at least temporary transfers to take care of situations in the different hospitals, it would help, I

RESTRICTED

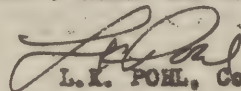
RESTRICTED

TRUE EXTRACT COPY OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 APR 48, Cont.

believe. Of course, while our Corps was small, all assignments were made from this office. The Navy, I know, still does that. They control all their assignments. Our is probably too large a group now for that to be done with some of our hospitals under Army jurisdiction, some Air Force, and some Class II installations.

BRIGADIER GENERAL MARTIN: Any complaints about regimentation of nurses?

COLONEL PHILLIPS: Not as much now as during the war. I think, again, that the fact was that they didn't know what the Army was. They were just brought in and thrown into a large organization with no orientation. I think that was responsible in a great measure for that. I don't think the nurses feel that there is so much regimentation.*****



L.E. POHL, Colonel, MC

RESTRICTED

RESTRICTED

(1)

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, ON 15 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** (L) 1. I think the first thing would be to set up a personnel procurement board on a defense level and allocation be made to the various services on the basis of their estimated requirements.

"2. I do subscribe to the common complaint that rank rather than professional ability governed in the command and control of doctors. Insofar as possible, promotion should be given to those who have both attributes.

"3. I don't believe that compulsory military service can ever be acceptable and pleasant to doctors. I don't believe it can be made acceptable and pleasant to doctors, but I think an effort should be made to make them more satisfied after they get in.

"4. As a matter of fact, I haven't noticed any great disaffection among the ASTP. It has been among reserve officers held on duty. It was predominant in reserve groups held on active duty after the war was over, -- those who were frozen because of one reason or another.

"5. No comment.

"6. I think the Surgeon General gets blamed for most of the trouble, whether he is at fault or not. I don't think the doctors know what part G-1 plays in the picture.

"7. I think that the commissioning of nurses has added to the disaffection of reserve medical officers, but not the regular Army medical officers particularly.

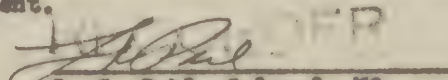
"(M) 1. I don't believe the basic complaint of the doctor is primarily financial. I believe his greatest desire in the Army is advancement and promotion rather than the actual pay involved.

"2. No comment. Basic training should start before medical school, in college and high school.

"3. I believe they should be assigned to field units during training.

"4. The alert system could be used and on-the-job training continued until they were alerted.

"5. I think that the joint medical board could have much to do with the classification of doctors and their procurement.


L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY COLONEL OSCAR S. REEDER, MC, USA, on 15 April 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.
(Continued)

***** "7. I believe that a Joint Medical Board should be formed on the Secretary of Defense level and that it should have the power and authority to recommend personnel allocation to the various services."*****

***** "15. I think one reason for subsidizing medical students during the war is to be sure they would not be utilized in combat."*****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E. R. HERING, JR., (MG) USN ON 22 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL & SOURCES.

***** L. "Medical Officer Dissatisfaction for the Armed Forces. I have thought of that, and it isn't anything that you can put your finger on exactly.

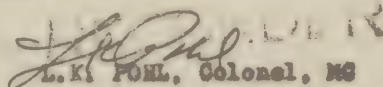
We speak a lot about morale among the enlisted personnel and take it for granted that officer morale is a fait accompli, because an officer is a leader and so forth, forgetting the fact that these doctors are civilians and that they don't get the 90 day training to indoctrinate into the military side of this thing.

Another thing that I know, from many, many complaints that I have heard from my own officers, is the wastage of medical officers doing paper work.

I know that steps have been taken along that line in the Navy by the formation of the Medical Service Corps. In my own organization I have to lean on them tremendously.

I understand, from a recent study that was made in the Armed Forces, that they are planning on the employment of these Medical Service Corps Officers, or the equivalent in the Army, in many places where medical officers were, realizing that we go into a war with a certain fund of medical officers which will not be increased during any short war and we have to preserve what talent we have. There is very little use in putting a medical officer up there where he is practically cannon fodder.

In the main, we have to pay more attention to the morale among medical officers. He is civilian that is brought in. The reason that we haven't done it before is because we think that an officer and his morale as being high because he is wearing an officer's uniform. It doesn't hold for these people, because they don't get the indoctrination.*****

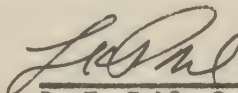

L. K. FOEHL, Colonel, MG

RESTRICTED

RESTRICTED

EXTRACT COPY OF PERTINENT MATERIAL CONTAINED IN AIR FORCE MEDICAL DEPARTMENT
HISTORICAL RECORDS OF WORLD WAR II. (1st Bombardment Division 44)

***** "Of the thirty-three surgeons who were marshalled in my group, there were three majors, two lieutenants and the remainder were captains. We were told that we had been selected because we seemed fitted and able to do this work which seemed to everyone to be so very important. Most of us have been in the Army for two years or so and have seen the average line officer advanced from enlisted man to captain or major during this time. A number of us have had no promotion since being commissioned, even though we may have worked hard and done good work at jobs which we did not like. Several have had little or no opportunity to do surgery since coming into the Army, allowing their surgical skill to fade through disuse. All of us look forward to the time when we may return to our homes and practices, and at least a few of us face the problem of explaining to former patients why we have not received promotions. This is a problem which is being faced even now, for some of us do continue a correspondence with some of our patients. Financial hardships do not add to one's peace of mind, and concern over what is to happen on one's home, insurance and other investments does not make for efficiency in one's work." *****



L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

True Extract Copy(Ltr N. C. Mashburn, Colonel, MC, AF, 18 April 1948)

****Attention is directed to the attached memorandum from the Surgeon, this Headquarters, same subject. A very thorough investigation was made of the situation in regard to Medical Department Officers, their attitude toward and their desires with respect to remaining in the service. This situation is clearly presented in the attached memorandum and inclosures thereto.

Unless the situation is very different in other Army Air Force Commands, which is exceedingly doubtful, it appears highly advisable that far reaching measures be taken to correct it immediately. Being a matter that could have such a direct bearing on the functioning of the Post War Army Air Force, the undersigned considers it his responsibility to bring it to the attention of the Commanding General, Army Air Forces.

I have taken and still take a deep personal interest in this matter. Since this Command was established in 1942, I have taken every possible occasion in inspecting the hospitals to investigate the morale of the Medical Officers. The Medical Officers of the Training Command are generally of the very highest type and were carefully selected. In the beginning, I noted great enthusiasm on their part and a great pride pertaining to the Medical Corps of this Command. During my inspections at the present time, I find that, while these men are doing their work conscientiously, they are doing it without enthusiasm, and that many of them are performing their functions with a feeling that they have been unjustly treated. Very few of them show the slightest desire to remain in the service.

This appears to me to be a very unfortunate situation, since the average of our Medical Officers is very high and it is an excellent opportunity to retain the best of the younger ones in the Post War Medical Corps.

I urgently recommend that this communication be given very careful consideration by the highest authorities.

1 Incl

Memo to CG, AFTEC
w/Incls. thereto

s/ B. K. Yount

T/ B. K. YOUNT

Lieutenant General, U.S.A.
Commanding

* * * * *

The Surgeon of this Headquarters is much concerned regarding the possibility of providing an adequate Medical Service for the post war Army Air Force. This concern is the direct result of a realization of the present poor state of morale of officers of the Medical Department and of their attitude toward remaining in the Service. Review of facts indicate that there are definite factors which are responsible for this attitude and that it is probable the situation will become even worse unless some corrective measures are promptly applied.

The attitude of any officer toward the service, which determines his state of morale and his desire to remain associated with the service, is bound to be tremendously influenced by the treatment he has received. Any officer, or group of officers, who believe that their civilian background of education and experience which equips them to perform their primary service duty has been discounted, are certain to feel they have been poorly treated. A large proportion of our physicians, surgeons and dentists are strong in their conviction that

RESTRICTED

RESTRICTED

their greater background of essential education, provided at their own expense, and their civilian experience, all of which has prepared them for their primary service duty, has been entirely discounted in the authorization of their grades.

Because of repeated indication that the situation referred to above existed, this Headquarters has made a study of the attitude toward the service of Medical Department officers as compared to other officers and has also investigated the factors which are believed to be responsible for the differences disclosed. This was done by the use of questionnaires filled in by Medical Department Personnel at all Training Command stations and by Air Corps Personnel at certain representative stations. The essential findings are disclosed in the inclosure to this letter. Those findings are such as to indicate that a very serious attempt to change the attitude of these officers should be made immediately.

A study of the facts seems to justify the opinion held by the majority of Medical and Dental Officers that the army has given relatively little consideration to the educational and professional background of training and experience necessary to produce a well qualified physician, surgeon or dentist and to the fact that this training has been at his own expense. Some of the facts disclosed are as follows:

a. Thirty-four and two tenths percent (34.2%) of Medical Corps Captains have been in grade over two (2) years, whereas but eight and six tenths percent (8.6%) of Captains, Air Corps rated, and nineteen and four tenths percent (19.4%) of non-rated Captains, Air Corps have been in grade that length of time.

b. Seventeen percent (17%) of our Captains, Medical Corps, were brought in from civilian life as Captains. A great many of these are highly qualified professionally and were very successful in their civilian practice of medicine and surgery.

c. Thirty-four percent (34%) of Medical Corps Majors have been in grade over two (2) years as compared with twenty-seven and five tenths percent (27.5%) of non-rated Air Corps Majors and twenty-four percent (24%) of rated Air Corps Majors.

In civilian life the professional background of training and experience of physicians, surgeons, and dentists is recognized. This recognition places them in positions of high responsibility in the community and, in addition, awards them by their relatively higher income. In contrast, the army awards principally those officers who, in addition to professional ability, demonstrate sufficient administrative ability to permit them to occupy certain advanced position vacancies and gives little or no award to purely professional responsibilities.

In connection with the survey conducted, officers were given an opportunity to express themselves as to their present attitude toward the service. Medical and Dental Officers were very frank in their remarks and those remarks are summarized as follows:

a. Embarrassment by lack of sufficient promotions within such a group of professionally trained men.

b. Very low income as compared with income earned in civilian life and resultant inability to properly care for outstanding financial obligations which have continued despite decrease in income. Many have now used up their financial

RESTRICTED

RESTRICTED

reserves which were utilized because of this necessity.

c. Discrimination against Medical Officers in the provisions for separation from the service. Many of them feel that other doctors should be brought into the service so that Medical and Dental Officers with considerable service could be released. This would not directly effect the officer who desires to remain in the service, but the general attitude of the majority toward the service has a very definite effect on such decisions.

d. Many Dental Officers are resentful regarding the end result of the ASTP program. The feeling is that government trained dentists should be brought into the army in order that those with considerable service could be released.

The most alarming fact revealed by the survey is that but four and nine tenths percent (4.9%) of nine-hundred and twenty-one (921) Medical Officers included in the survey (Regular Army excluded) have any desire to remain in the service permanently. Of this small number, none (0) are Lieutenants, twelve (12) are Captains and eight (8) are Majors. The remaining twenty (20) are Lieutenant Colonels. Only twelve (12) of all the Medical Corps Officers in the grade of Captain or below, or one and eight tenths percent (1.8%) of those surveyed wish a regular commission. It could well be that an elimination of undesirables would considerably reduce this small number. The situation in regard to Dental Officers is somewhat better, but still unsatisfactory, there being but nine and two tenths percent (9.2%) who desire commission in the Regular Army. These figures compare very unfavorably with the twenty-seven percent (27%) of non-rated and forty-nine percent (49%) of rated Air Corps Officers who desire to remain the service.

Whether or not Medical and Dental Officers are completely justified in their firm belief that they have not been accorded reasonable treatment by the service, it is a certainty that the great majority of them are convinced that they would fare very much better in civilian life than by accepting a commission in the Regular Army. Under the present law, six months after the termination of the emergency all of them (except Regular Army) can revert to inactive status. Unless immediate action to change their attitude is taken, very few will remain other than the Regular Army Officers whose number was sufficient only to care for the needs of the small pre-war peace time Army Air Corps and who have been required to give up their professional work for the Administrative work required of them during this emergency. The seriousness of such a situation requires no emphasis.

It is considered highly important that immediate steps be taken to recognize the essential backgrounds of education and experience of these officers who came to us already trained at their own expense by instituting an immediate and radical change in the basis of promotion of Medical Officers and by immediately providing a promotion for a large majority of those highly qualified professional men who have been stymied in relatively low grades, particularly in that of Captain. Only by such action can we hope to influence an adequate number of these officers to remain in the service and thus provide for an adequate post-war medical service for our Air Force.

In order to accomplish the desired result it is imperative that action taken be two-fold in scope and the following is recommended:

RESTRICTED

RESTRICTED

a. Immediate action to bring about a large number of promotions of Medical Department Officers, particularly among that group of highly qualified professional men who entered the service as Captains and have received no promotion. It is hoped that such action will not be too late and may, in part at least, overcome the conviction that these officers have, that the Army has given them no credit for their professional background and has not given them a fair deal.

b. Recognition of the essential background of professional education and training of physicians, surgeons and dentists by setting up and putting into immediate action a post war plan for commissioning them as officers in the Regular Army in grades which would induce a sufficient number to remain in the service. "*****"

RECORDER

L. K. Pohl
L. K. POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M. J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

***** "(1) The chief points or circumstances within the military structure contributing most to apparent disaffection of medical personnel.

As I have stated before in this letter when medical personnel were actively engaged, their morale was high. It seemed that only during periods of enforced inactivity was there any noticeable degree of discontent. Service jealousies and jealousies of individuals within the same group undoubtedly were present, but I do not believe this was true to any great extent. Some medical officers protested that their special knowledge and capabilities were not being properly employed. I believe that adequate adjustments were made in these cases as soon as was practicable. Certain medical officers considered that their professional standing in civil life should have entitled them to higher rank, perhaps some of these individuals were justified yet I considered that on the whole our reserve medical officers were fairly and very well treated. Apparently few complaints of this nature came from medical officers of the regular establishment. The promotions in the army medical corps were thought to be more advanced and accelerated than those of the navy medical corps and several instances of this sort were brought to our consideration. Perhaps this is more understandable when one realizes that the Medical Department of the army expanded to a far greater extent than that of the navy.*****

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

(1)

TRUE COPY EXTRACT (Letter, Captain F. R. Urban (MC) USN
dated 28 April 1948)

***** "(1) The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel.

"(1) In the Army there was a lack of opportunity for either professional experience or military promotion for medical officers in tactical units.

"(2) A better understanding and more friendly relationship of regular and reserve personnel.

"(3) Rank of reserve officers not commensurate with age and experience.

"(4) Experienced personnel in medical lines receiving administrative positions. Administrative officers in many cases could have taken over medical officers billets."

L. K. Pohl

L. K. Pohl, Colonel, MC

RESTRICTED

765

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel James H. Forsee, MC, USA, dated
20 April 1948)

**** "(L) The Chief Points of Circumstances Within the Military Structure
Contributing Most to the Apparent Disaffection of Medical Personnel.

Most disaffection with the military structure relative to medical personnel is I believe related to personnel management. Such factors of uncertainty of assignment interfere with future planning on the part of the individuals and disrupt professional education. The frequency with which moves are made in rather a hurry-up nature only to find on arrival that an appropriate assignment is not available is indeed discouraging. Many of these factors are not Medical Department difficulties alone by any means but they do have a very definite influence in discouraging the young officer contemplating a military career in the medical department. Inadequate housing is one of the most major problems which we now face in securing doctors to enter the Service. The present pay levels do not permit junior officers to be attracted to a military career. The following is quoted from a recent article in the Surgery, Gynecology and Obstetrics of April the 17th, 1947 written by Dr. E. D. Churchill:

"Pearl Harbor found the civilian medical profession in mass of poorly integrated but highly developed specialization in remedial medicine. The prevailing tactical situations in World War II permitted the useful application of wide varieties of specialized technique to injury and disease. The range of these techniques had not been anticipated in the plans of the Army Medical Department and particularly during the early phases of the war Medical Officers found difficulty or frustration in their attempts to apply their full potential. An unenlightened attitude of Command toward the mission and operation of the Medical Department was not wholly surprising. It can not be assumed that tough-bodied and tough-minded laymen will have a full appreciation of the functions of doctors and hospitals. Even a lay Board of Trustees in civilian hospitals required education. Medical staff officers only rarely were vested with the authority that is derived from having the ear of command. It was difficult for them to make the voice of Medicine heard above the clamor. The wound surgeon by virtue of his direct clearly understood mission, fared better than his colleagues in so far as it pertained to sanitation and hygiene, was well carried out; but warnings and advice regarding hazards that had not been visualized in Army peace time training and discipline were likely to pass unheeded---. It was difficult to reach the Command with authoritative advice regarding these hazards and it was not always followed when heeded. A total health program utilized the knowledge and experience of the medical profession regarding "man and all that concerns him was never envisioned--".

"The role of the doctor in war must always be that of his role in civilian life--an advisor. There are only two essentials: First, the advice must be sound, and second, it must be heard---".

RESTRICTED

RESTRICTED

These factors seems to me to add up to simply this. That the Medical Departments of the Armed Services must present a sound policy and aggressively pursue its accomplishment. Too long have we as a group feared or hesitated to strenuously present our demands to the General Staff and the people. We have accepted a budget too small to carry on the required pursuits of the Medical Department. We have failed to achieve high professional recognition within our own medical societies and organizations. The Armed Forces should and will be just as good as the people want. The people must however be properly advised as to its needs. The demands for superior leadership on the part of the Armed Forces including the Medical Department was probably never greater. An adequate Armed Force is costly. The successful prosecution of the present objectives of the Medical Department are likewise costly. Its achievements cannot be gauged solely by material expense. Its record during the last World War in the saving of lives, and medical care of the sick and wounded has won the highest praise from all sources. This fact must be constantly called to the attention of the Command. The people must be willing to pay a dear price for peace for the price of War to this nation and to the world will be greater than death itself.*****

RECORDER

L. K. Fohl
L. K. Fohl, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY:

Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1948 at interview with Subcommittee on the Employment of Military Medical Resources:

***** L. "I think that the common complaint indicated is that I can only be covered by proper planning which goes back once more to the medical people knowing in advance the high levels of strategic plans insofar as procurement is indicated, and then a proper classification of medical manpower, a calling to duty of this manpower only when needed, and a keeping of this manpower busy by rotating them from one busy spot to another, and then a properly-trained administrative head -- by head I mean staff -- at the head of the medical department to understand psychology, promotion, justice, and just the general over-all make-up of the medical man to try, insofar as possible, to minimize the causes of this type of complaint. I think it requires a lot of thinking, a lot of planning, and a lot of good sound common sense back of it.

I personally believe as far as No. 2 is concerned that promotions should be based on ability. Whether that ability is largely professional, or whether it is demonstrated in some other field, I still think it should be on ability rather than on just some particular faculty. By this I mean I don't think that because a man has done a certain thing for so many years or because he is a member of some particular society that that in itself alone should justify promotion. I think a promotion is an indication of the man's relative value to the over-all medical service. That value can be equal in a professional field or in an operational field, depending on where he is needed.

At least one factor not under the control of the surgeon general which results in disaffection of doctors is the quarters situation, possibly because a greater proportion of the younger doctors are married and have families than the younger officers. I don't know, but I do know that the chief cause of dissatisfaction that I hear is the fact that officers can be moved from one place to another don't know where they are going to go and don't know whether they are going to have their families with them.

I know there would be an awful lot of dissatisfaction if they started bringing women in the regular Army. That's what they are talking about right now. Pay of doctors in the Army should be the pay of any other officer in the Army of a comparable grade. I would like to answer yes to that one, providing it wasn't pushed up above anybody else, but distinctive pay, pay for special efforts, or for special training or for special anything is not appreciated by other branches of the service, and when a fellow has to eat with and live with officers of another branch who are jealous of him getting extra money, it causes a lot of dissatisfaction. It is discriminatory legislation. As much as I like dollars, I rather not have it than have a lot of people feel the way they do about it.

I don't know how to answer that question. If you are going to get doctors into the Army for a career, at least one consideration is how much money they make, and they would like to make as much money as they make on the outside. If you can demonstrate that they actually take home as much money in the services when certain advantages are considered and what not, then you have actually increased their pay to a comparable civilian level, and I am certainly in favor of professional people getting what they are worth, but I am not in favor of doctors in the Army getting more than other officers in the Army.

RESTRICTED

RESTRICTED

L

EXTRACT OF STATEMENTS MADE BY

Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April, 1948 at interview with Subcommittee on the Employment of Military Medical Resources. Continued:

I can't answer No. 2. The reason I can't answer it is that I am forced to feel that there is too much personal selfishness exhibited all over our country today. Everybody is for himself today, and I don't believe you can talk about sacrifice and get any enthusiasm out of anybody. The doctor that goes into medicine with the motives that he should go in is sacrificing anyway. He is giving his life to take care of other people. I think a true doctor has that spirit of sacrifice in him all the time.

RECORDED

L. E. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USN
4 May 1948.

*****L. "REAR ADMIRAL ANDERSON: The next subject is the chief points or circumstances within the military structure contributing most of the apparent disaffection of medical personnel.

REAR ADMIRAL WILLCUTTS: I have two or three factors that I think covered all the disaffection I saw.

One was, as I said, an absence of military planning and military knowledge by the doctor. I have referred to that case. The doctors were dissatisfied because they didn't know what the score was.

The next one was due, I think, to a faulty induction -- a faulty concept of our type of patients. The inductees would go to the induction center and then to the training center, and then, instead of being sent home after being screened at the training center he would be sent to our hospital. Out of a 12,000 population of patients, 2000 of them were on NP service; and out of that 2000, I dare say 90 percent were just a type of disgruntled boy that could have and would have fought well had there been a battle on right there in San Diego. But they found they wouldn't team up and they sent them to us as NP cases. I know I had 2000 of them at San Diego. A proper screening early might have put most of those boys out of combat duty entirely and kept them in another productive type of duty. He might not have been able to do combat but he could do something for the national economy other than fighting. My doctors got very dissatisfied at times because ward after ward of patients, were not very sick, and that is not good clinical medicine. The doctor became annoyed. He would go in on sick call and see a whole line up of boys not too sick and that could be sent to duty. They had to have a little dental care; they had to have this and that. And the law says they would rate 30 days leave. The doctor was annoyed by the enormous amount of paper work he had to do on a not very sick patient. That made for disaffection and discontentment among the staff at the hospital.

To get away from that means very careful selective service based upon, I think, an improved induction system. I can't see why we can't take an examination at the home base by the local doctor, the selective service doctor, who is a civilian. He will know whether that boy has epilepsy; he knows that boy. He knows the gross disability without screening. The other man can't know too much about it. So instead of going to the induction center I would like to see them come right to the training center on probation, so to speak, a probation enlistment, and then after 3 or 4 more studies by a good number of doctors, including a psychiatrist, they would try to screen out those boys who will never make good combat material. It is going to be difficult and it is going to take a lot of careful scrutiny. But, as I say, the next war is going to be total war, and certainly these boys can be made fire watchers and rebuilders of destroyed houses and firefighters. They can do something. In that way then, in our hospital we would have clinical material and proper morale among our doctors. The morale will be higher. That was a serious morale among our doctors. The morale will be higher. That was a serious morale factor, the clinical material we had. Nothing shot up the morale higher than to have a new boat load of war wounded boys come in. Yet, they came in with a bunch of sea-sick kids. They would just groan and say - here are some more of these boys, these misfits.

Then, of course, there is the third group that wanted to be in bloody surgery all the time. You can't do that. As I told the boys on the LST - what do

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USN
4 MAY 1948, 1. CONTINUED:

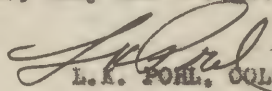
they want us to do, explode them, get a kamikazie to cripple a third of the ship so they could have some surgery to do. I told them if they were not here other doctors would be here, that they are filling a necessary billet. That has been thought out, carefully thought out, that these surgeons checked all these needs and determined we do need on this LST, from our experience in previous near disasters we had in other island hopping in the Pacific, extra doctors.

Of course there always comes the loss of comforts known to the doctor at home. He can't get housing; he can't bring his family perhaps; perhaps his schooling is upset, and so on. Many of our doctors, as you all know, are in debt. They may look like grand successes outside, but they have a mortgage on their home, insurance to maintain by high monthly contributions, and so on, and service pay doesn't cover much. I don't think the discontent was too much. I think they were poor sports. A lot of these people that are disgruntled now say that we did this and we did that. I have talked to many of them and asked for definite items that would create discontent, and they can't give me a good answer to my satisfaction.

I did feel a loss of morale with the poor type of clinical material. Doctors also like to have a little firing, a little gunner, a little action. Many of these doctors were good sports, as you know, and they want to see action. And to go home and see no action - to go back home and be applauded for home work is not their idea of good sportsmanship. They like action.

I am not too disturbed by the AMA questionnaire that went out. If you analyze them those questionnaires were well done and those doctors were serious in their replies. But they are not too serious, I don't think.

As I said a minute ago, what if you had not had the doctors at the Bulge and that Bulge went on down to Southern France? What if we had landed on the China Coast and the mainland of Japan? The civil people would have had to have given us more. And when they tell me they were down to 1 to 1500, I tell them I have checked the morbidity of the civilian communities and it was startlingly low. They had no great epidemics. The morbidity rates throughout the country was very favorable. I can't give civil medicine very much credit there. I call it poor sportsmanship. When you talk to them over a cockrail, they don't fight much. *****


L.R. FORL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL CORNELL, MC, USA, 30 APRIL 1948

***** L. "The chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel". All doctors resent the loss of individuality. I think that is the basic reason for dissent. They resent service other than medical duties, and they resent medical duties other than those in their own line of practice, and they resent direct orders. With training and experience, those features are minimized. Consequently we must start before mobilization by inculcating the idea in the medical fraternity of what the Service does and has to do.

I know they don't like to hear a lot of that, but there should be some way that we could give it to them in an interesting manner and by encouraging attendance of medical officers at the various civilian meetings. I think personal salesmanship again is most important in letting the civilian doctor know what the level of medicine is in the Services, and that even though we have to do some of these administrative tasks, we are getting a lot of good professional training and very good professional work.

Only since 1936 have Army medical officers attended medical meetings on a duty status. The Public Health Service has been doing it for years. The Public Health Service has been doing it for years. When I was curator at the Army Medical Museum for three years I paid my own expenses to all of the general meetings, but started a movement to have the curator and some other representatives sent to these meetings, which is now being done. I think that that should be continued, and should be encouraged.

Now the policy is that you can't go to a meeting unless you present a paper. Well, I think that some men should be allowed to go as representatives, even if they don't have a paper. I think their very presence there in uniform is worth a whole lot of to all of the services.

There is general professional resentment that professional men are not recognized in the higher grades, and that immediately a professional man is recognized he generally ceases to be professional.

As evidence of that you can take the remarks by one of the men from the Surgeon General's office before a civilian group just the other day, in which he stressed that one of the recent promotions was of a professional man and that that man was going to continue in his professional duties, and the very reason it was emphasized is because perhaps its one of the first times it has happened. I think it is possible and should be, that that could be done more often. I think that that is one of the things that the general profession know.

The younger men resent breaking of training periods in order to meet other needs of the Service. They have to go to certain jobs, but that fits in with what I said a while ago, that as long as we are under-staffed, we never are going to be able to let a man continue the period of training without needing him somewhere. Whether we can meet that, I don't know, but that's one of the things that irks the younger men as they are sent somewhere to train in some subject and then after a year or year and a half, when they are supposed to be taking a three-year course, they are pulled out and sent somewhere.

The rapid changes in policies have instilled a distrust for the future among young men, both in and out of the service.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COL. CORNELIUS, MC, USA, 30 A 11 1948.
L. CONTINUED:

The next item comes from my Division Surgeon; Failure to comply with promises of professional rehabilitation for frontline medical officers upon their return to the ZI.

Those men are immediately demobilized. The G.I. Bill of Right was not in effect, so they couldn't take advantage of it until sometime after they had returned to their practices, and then they were established and didn't want to. But he tells me that many of the men who had been banking on that period of rehabilitation to get back into their medical work after a period of combat duty were much disgruntled because that never developed, although it had been promised to them.

I can't personally say anything about that other than report that that is one of the comments I have heard along that line.*****


L.E. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (from address of Major General Albert W. Kenner, MC, USA
13 May 1948)

MAJOR GENERAL KENNER: *** "Going on then to the next one -- the chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel -- I will only mention a few of them.

There was denial of opportunity to advance professionally. That was particularly noted in the attached medical. Your battalion surgeon was stymied on promotion as long as he stayed with the unit to which he had a certain amount of loyalty.

BRIGADIER GENERAL MARTIN: Do you favor a more specific rotation policy than that used during World War II, where it was left more or less to the various theatres and lower level surgeons?

MAJOR GENERAL KENNER: I do. I think the assignment of medical officers within a combat unit which precluded their relief within a reasonable period of time is one of the reasons why we had some disaffection. I noted that even after the war was over these medical officers had been denied any chance of professional advancement. They were still being denied refresher courses or assignment to major medical installations when they could very easily have been replaced by others who had had these advantages.

Rotation of assignments were not afforded. Many junior officers were kept in general hospitals, in many instances when they could have been very easily spared. They went through the whole war in some base. There should be proper assignments. It is an improper assignment to take an older medical officer who is well qualified professionally and give him an assignment as a battalion surgeon. That is a young man's game. In many instances I would find battalion surgeons of 45 carrying on a job, but they certainly had physical limitations that the younger men wouldn't have had. They were not being used to the best advantage of the service.

There was restriction on professional initiative. That is another complaint, particularly of the younger men, because they had to adhere, in application of their professional activities, to concepts laid down by either the Surgeon General's Office or by some local chief of the service who was insistent that a hernia operation be performed his way rather than letting the individual perform it in the way he was accustomed and using his own initiative, with equal good results. They resented what we might call this professional regimentation.

RESTRICTED

RESTRICTED

- 2 -

Another complaint was delayed promotions. I think we mentioned that before. Our system of promotion, to my mind, left considerable to be desired. So much depended upon where the officer happened to be and whether or not he was particularly in the high esteem of one who was capable of getting him the promotion.

BRIGADIER GENERAL MARTIN: In view of the present move to replace many medical officers, especially in those assignments in the hospital where they do administrative work, by MSC personnel, many of whom will hold advanced rank -- will this process add to the disaffection in stymieing the promotion of medical officers within that unit?

MAJOR GENERAL KENNER: It shouldn't. It shouldn't if we establish for all key positions, for all positions of responsibility, certain grades that the individual officer occupying the key position will get immediately upon his assignment to that certain position. Promotion heretofore has depended upon a lot of factors that are not conducive to high morale.

During the past war an officer was eligible for promotion in the next higher grade after he occupied the grade for a certain period of time. But that didn't mean that he got it. It did mean also that some officers got their promotion who did not perform the duties commensurate with the higher grade. So there were inconsistencies there which reacted unfavorably.

In view of our shortage of medical officers in the Armed Forces we shouldn't have a medical officer doing any job that does not require a medical officer.

BRIGADIER GENERAL MARTIN: In that connection, recent legislation permits the permanent rank of nurses, many of whom are in high grades within the hospital structure. In your opinion will that add to the disaffection among the medical officers, especially the junior group who can never attain comparable grades that the nurses hold by matter of assignment?

MAJOR GENERAL KENNER: I think that is one of the biggest mistakes that we made. In the first place, the interne considers a nurse more or less subordinate to him. That is fundamental in the medical profession. That has been my experience. And to accord nurses actual rank, whatever interpretation you may apply, conveys a certain command responsibility which I believe is certainly detrimental to the morale of the medical officer.

RESTRICTED

775

RESTRICTED

- 3 -

(Off the record)

Another thing that I think has created a point of dissention is the creation of a schism within the medical corps as between the specialized medical officer, who is being placed in a preferential class, and the administrative medical officer.

I think, as we all know, it was proposed before Congress to give the specialist a 25 percent increase in base pay because he was a specialist. The fellow who had been denied a chance to be a specialist because of assignment over which he had no control, with field medical units, felt that he was being relegated to more or less an inferior category within his own corps. That is another reason why I propose this military surgeon specialist MOS. Then he, within his own right, becomes a specialist and gets more pay than anybody else, which will attract a lot of your young medical officers for service with troops. I think that is one way of procuring more medical officers.

If this young interne coming into the Army goes through a medical service school and the infantry school, or a combined Army school where he gets knowledge of the tactics of war, and then he goes on to Leavenworth and the War College, and so forth, and he knows that his promotion depends upon his MOS, as he earns his MOS and gets assignment to higher echelons and is on the way up, he is willing to stay with the Army. The other fellow who likes to pursue a specialist course, when he attains everything that he can attain professionally and the recognition that goes with it, is much more prone to resign from the Army and go out into civil practice than this fellow who specialized in military medicine.

Now in general there appears to be considerable difficulty in obtaining doctors for the Armed Services that will eventuate in an inability of the Medical Corps of the Armed Services to meet their commitments. The appreciation of this situation is apparent to all.

The solution of this problem may be approached from several angles.

a. The reduction of commitments by:

(1) Not assigning a medical officer to any duty not requiring a medical officer, which is capable of being performed by an officer of some other branch of the service;

(2) Transferring cases with no military potential to the Veterans Administration, or other facilities as soon as determination of the non-military potential has been made, which should be apparent

RESTRICTED

RESTRICTED

- 4 -

very early;

(3) Withdrawing privilege of medical care to civilians;

(4) Training nurses and MSG officers in the performance of some professional duties now requiring a medical officer. There are a lot of minor functions of a medical officer that a nurse of intelligent individual may be trained to perform.

(5) Adopting administrative measures designed to lighten the load on major medical installations. We should have an administrative procedure that will accelerate the return to duty from general hospitals.

We all know that general hospitals in some cases have patients who do not require the facilities of a general hospital in the first place, and that there is administrative delay in returning them to duty that would not occur if the individual were hospitalized in a station hospital servicing his unit.

(6) Acceptance of patients from one Armed Service into hospitals of another. That is, the Navy having a hospital with plenty of empty beds would accept patients from the Army or Air, and the other way around.

(7) Assignment of medical officers of one Armed Service to medical installations of another in a temporary duty status under certain circumstances. If you have a balanced staff in a hospital that has few patients and the Navy, for instance, has requirement for an ENT man, and you have a couple in your Army hospital, why may not the Army medical officer be brought into the Navy hospital on a temporary duty assignment?

(8) Utilization of civilian medical installations on a per diem basis with limited bed credits.

(9) Utilization of medical reserve officers for physical examinations and dispensary care for small elements by calling them to active duty in their places of residence, or authorization to permit the President to call any medical reserve officer to active duty who has had less than 6 months continuous active duty. The emergency is still on. The reserve cannot resign his commission during the present emergency. He may later when the emergency is declared off.

b. Subsidization of medical education as a long range project by commission in the MSG and school assignment of superior graduates of premedical colleges. Whether we may establish within our structure,

RESTRICTED

RESTRICTED

- 5 -

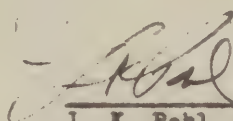
notably at Walter Reed and Fitzsimons, the Army medical colleges that will meet the requirements of the AMA and also meet the civil requirements for medical colleges, and have, as West Point has professors with appropriate rank, or some other way, is something I don't know. It seems to me that is one way of securing medical officers, because the lad who is so educated signs up for five years. If he is in excess, he is then placed into the reserve. In that way you will be getting superior young men who thereby would be serving the civilian communities and the Army. You are building up a pool of trained men who have had 9 years of military life. Those who do not desire to make the Army their career after this five years of duty can go into the reserve pool. There are a lot of young men who would like to study medicine today but who can't afford to study medicine.

There is precedent for this in both of our Service Academies, in the Navy and the U. S. Army. If the Government can afford to educate line officers for service in the Armed Forces, it certainly seems to me they may also afford the education of medical men. That is a long range policy, and it would take some time to build that up. However, if we had started it two years ago, as I once proposed, we would have been two years up on it, and in another two years we would have started to get some results.

c. Drafting of doctors upon graduation as an immediate project before they have established themselves in civilian communities, to include ROTC medical students.

That will probably be acceptable to doctors in that category if they were assured of interne and residing training. They get that training usually at their own expense, and here the Government is offering them that training. They would therefore relieve our general hospitals of some of these requirements for Regular officers.

I think that is all I have gentlemen. I am sorry I have kept you.*****


L. K. Pohl, Colonel, MC

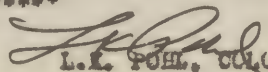
RESTRICTED

RESTRICTED

REPRODUCED FROM COMMENTS BY AIR FORCE MEDICAL DEPARTMENT OFFICERS, ANDREWS FIELD, TO COL. L.K. POHL, MC, AS PROVIDED INFORMALLY MAY 20, 1948.

***** L. "The above are only a few of the outstanding inadequacies in the administrative control of the average station hospital and I believe the resultant is the obvious lack of interest shown by World War II ASTP Medical Officers and Junior Medical Officers in any military service what-so-ever.

The small military hospital, subject to a multitude of non-medical policies and regulations cannot compare with the civilian hospital, when left as a matter of choice, especially to a doctor who has been trained in an atmosphere of professional ethics. The military can and does break this code of ethics in the simple procedure of forwarding clinical records. Clinical records must have a reports control symbol, as much must be processed through Statistical Control officers and Message centers.*****


L.K. POHL, COLONEL, MC

TRUE COPY EXTRACT OF INTERVIEW WITH BRIGADIER GENERAL JOSEPH E. BASTION, MC, USA (RETIRED) ON 3 May 1948.

***** L. "To me, it's hard to say. Actually I haven't heard of much dissatisfaction. They are getting everything under Heaven. This is off the record -

BRIGADIER GENERAL BASTION: You know it, too, that between the first and second world wars there grew up what might be called general hospital groups. If the younger man was not able to get into those groups- and not only was it professionally - why he was on the outer circle and lost out professionally during his whole career. Right now the dissatisfaction - I don't know what it is. Let me say off the record --

BRIGADIER GENERAL BASTION: Dissatisfaction in any medical group - I don't know what you would call it in the Navy or Air Force, but that's what I mean - can be greatly eliminated by the attitude of the commander, the medical commander. Therefore the training of our officers, field officers - you call them flag officers, don't you, Admiral?

REAR ADMIRAL ANDERSON: The flag officer is the same as a general.

BRIGADIER GENERAL BASTION: No, I mean along about majors, or lieutenant commanders, up in there -

REAR ADMIRAL ANDERSON: I don't know that there is any particular term for that group. They are simply senior officers. Junior officer goes up to lieutenant commander inclusive, and senior officer is above that, and the flag officer corresponds to a general.

BRIGADIER GENERAL BASTION: Their training, because they are the ones that are going to have these groups when the big emergency comes, should be towards doing away and seeing that these dissatisfactions don't occur, and it's a case of leadership. That's the whole answer.

REAR ADMIRAL ANDERSON: There is another question here that I would like to ask, if I may. During the war in the Army there were promotions of officers who were attached to organizations where the T/O called for an officer of higher rank.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH BRIGADIER GENERAL JOSEPH E. BASTION, MC, USA
(RETIRED) ON 3 May 1948. L. CONTINUED:

BRIGADIER GENERAL BASTION: Yes, sir.

REAR ADMIRAL ANDERSON: And the officers were promoted to fill those vacancies. In our organization we called these promotions spot promotions. With the Navy the spot promotion held only so long as the officer held that position. Were he transferred to some other duty, he lost his promotion. Nevertheless, it caused a good deal of dissatisfaction.

Do you have any suggestion as to how the system of promotion can be modified to avoid dissatisfaction among the officers that are not fortunate in getting promotion?

BRIGADIER GENERAL BASTION: I don't think you ever can have it. You are going to have it, sir, no matter what kind of a system you have, but you can be so fair - there again the men in the higher echelons must be as fair as humanly possible to be in all these promotions.

Now, if I were promoted because of your spot promotion, I would resent it a great deal to have to be demoted just because somebody wanted to move me somewhere and if I stayed at that place I could hold it. On the other hand, in some groups where they were promoted because of - what do you call them - vacancies where they had no regular T/O, that was a case mostly of selection in putting in the names, and you had dissatisfaction there too.

I don't know, sir. You are going to have it anyway. Jones gets promoted over Smith and Mrs. Smith resents it and she tells somebody else, and so on down the line, tells the Senator, or somebody, so the only thing you can do is make that promotion business as fair as it can be, the whole group, and see that it works out according to the regulations, and so forth, with no favoritism.

BRIGADIER GENERAL MARTIN: Has the commissioning of nurses, and other females, in the VSC and the WAC added to the dissatisfaction of medical officers?

BRIGADIER GENERAL BASTION: Well, individuals, I would say, to some degree; but as a group, I wouldn't say much. As far as my personal experience was concerned, I saw very little of it. It could happen, and all the other things. However, with the commissioning of the female personnel in the Medical Department, I did observe that the WAC's would assume responsibility and take direct charge of whatever duty they were given, whereas the nurse shrank responsibility and did not want to take any responsibilities of her commission unless she was forced to do so - except a few older regular nurses.*****


L.E. POHL, COLONEL, MC

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Quinton M. Sanger, RETED, USN, 15 April 1948)

**** Young reserve officers complained that they received inadequate internship training. It was held that if such officers were enabled to study patients after admission to a hospital that clinical interest would be increased and morale improved. Internships in Navy hospitals in 1945 were claimed to be inadequate. Improvement would induce more medical officers to remain in the Navy.

It was proposed that there should be an automatic 25% increase in base pay for medical officers who have the ability and initiative to qualify as diplomates of Specialty Boards. This proposal was made in 1945 and also of course in 1947. It was recommended that a Diplomate be commissioned at a rank no lower than Lieutenant Commander.

The "running mate" system which ties the medical officer entering the Navy to the lowest man in the Annapolis class three years previous, was criticized. The medical officer has had nine years education and the comparable line officer seven years.

It was suggested the running mate system be abolished, and that the Medical Corps be permitted a separate listing of ranks based on qualifications and length of service.

It was claimed morale suffered when an officer was passed over for promotion because of restrictions based on percentages of "the line."

It was contended that the Selection Board system of promotion encouraged favoritism and stifled initiative. It was suggested that the plucking system should be revised to "select out" rather than "select up."

It was suggested that the privilege of voluntary retirement on two-thirds pay at the end of twenty years' service be extended to the Medical Corps.

A navy medical officer's prerequisites compensate in a considerable degree for the higher pay of civilian doctors. However, his retirement pay ceases at death. It was recommended that consideration be given to the need for an optional joint survivorship system of retirement pay. In some cases wives of officers who died shortly after retirement are on navy relief.

Doctors entering the Navy claim they have no assurance of an orderly rotation of duties, and sometimes are given too large a share of the "SCUT" work.

It was suggested that the young medical officer be given a more specific outline of duties and assignments which he may expect during the first few years of service and that steps be taken to ensure that so far as possible, such assurances be carried out.

RESTRICTED
L. K. POHL
COLONEL, MC
RESTRICTED

RESTRICTED

1. There is a predominant thought and universal desire expressed in the hope for realization of the fact that conditions of future warfare will be radically different from those as prevailed during the past war. A comment that "apparent correction of some deficiencies of World War II may open the door wide to more serious deficiencies in the next war" is deemed appropriate for repetition here.

2. The supporting data reproduced for reference under this project's title has been limited and it is also in wide variety of subject content. It was felt that the subjects originally outlined and for which information and comments were requested, allowed for ample placement of practically all desired material and would facilitate ultimate breakdown as has been done, for use as supporting data and with the most possible appropriate subject association. As a consequence, miscellaneous comments and varied, sometimes repetitious material, are included under this heading. These include:

- a. Assignment and promotion difficulties of the Nursing Corps of the Navy.
- b. Difficulties of the Army Nursing Corps in regard to uniforms.
- c. Establishment of Armed Forces basic Medical Schools for peacetime needs and the cost thereof compared with that required to train pilots.
- d. Appointment of civilians to committees now dealing with various aspects of the Medical Services of the Armed Forces.
- e. Streamlining of Medical Sections of less important commands.
- f. Need for adequate planning and readiness to deal with problems of civilian defense which will arise from new methods of and total war.
- g. Requirements for adequate intelligence information on medical matters from various countries where such information is not now available.

3. The development of top offices with, simply stated, the maze of paper work associated therewith as evolved during the year 1939-1948 has extended its tentacles from varied Government activities into all Medical Department echelons. As a part of the Military Estab-

RESTRICTED

RESTRICTED

lishment, it is firmly believed that an abrupt about face in the matters of statistical control elements through all levels and a concerted unified reduction of reports, paper work and artificial offices is most urgently indicated. During the war in many instances it could be truly stated; "the unit accomplished its mission in spite of the existence of interfering and top heavy higher agencies". Ability to conduct defensive warfare without major hysteria and by decentralized simplified authority based on appropriate standard operating procedures should be a major goal in the education of the Medical Department structures and in fact, it is believed should be considered by the other branches of the Military Establishment. Centralized control with multitudinous reports and complex procedures will result in mass confusion and impotency as a result of a direct hit by one atomic bomb. Now is believed to be the time to plan and if possible establish self sufficient medical echelons capable of assuming full operational control for such action demands for which they may be called upon. World War II, medically, was in large part, original holding action followed by multiple objective large scale offensive warfare. The ability to fight another war under such favorable conditions should not be considered certain at this time. The thought "defensive warfare" is repugnant to a victory imbued and educated people and is therefore better contemplated only to insure that as such, it is conducted as an adequate "holding action". Dispersion of industry, populations and of military establishments is believed to be a major requirement in the event of total war. The Medical Department should make an all out effort to adjust their thinking accordingly.

4. One of the factors which must be considered as falling within this field concerns the utilization of service medical personnel and facilities for the care of civilian populations of occupied countries during and after war. In World War II it was an accepted practice to care for civilian injured in the Combat Zone. The Military Government organization was designed to embrace medical matters in these countries. That it worked under great difficulties is well known. On the Field Army level it was organized with a complete staff including medical and operated as a general staff section. This did not afford the Chief Surgeon of the Army control over civilian medical matters in his zone of responsibility. It in practice led to the necessity of taking over critical situations that could not be handled by the meager personnel of the Military Government Section as each crisis arose. This indicates the need for a thorough study of the system used during the war in an effort to evaluate its soundness on experienced factors. It has been suggested that all medical matters in any specific area should be placed within the realm of responsibility of the Chief Surgeon of that area and that his staff should be implemented accordingly to care for civilian needs. This practice would have obviated the instances where conditions forced his intervention in this field in order to protect the health of the troops as well as provide some merciful attention to the helpless.

5. Certain attributes of Navy Department General Order No. 245 dated 27 November 1946, have been pointed out as being most applicable to the Command and Operational Procedure most adaptable for the larger medical installations of the three Armed Forces. Paragraph 3 defines Command as the "authoritative direction exercised over a unit or individual..... in all matters,.....not specifically excepted by higher authority and is commensurate with the responsibility imposed". It continues and includes

RESTRICTED

RESTRICTED

the following four components of Command, with responsibility in each component commensurate with authority and each containing the authority to make appropriate inspections: (a) Military Command.....authoritative direction, (b) Coordination Control.....to insure adequately integrated relationships.....(c) Management Control.....direction exercised, in other than military matters.....; in routine administration and control of its local operating functions; (d) Technical Control.....specialized or professional guidance exercised by an authority.....in technical matters that have been assigned to that authority. Continuing, each activity is considered subject to the exercise of one or more of these components as may be designated. In general, the designation for Military Command and Coordination Control are deemed properly to be of the area or local Command. Designation for Management Control and Technical Control is believed usually best concentrated to the higher technical echelon. It is believed that further study in this regard as applied to Army and Air Force Medical echelons may be of considerable benefit for future definition of responsibilities and authority.

II. CONCLUSIONS

1. That the wide variety of subjects included in this category do not justify a specific conclusion for each at this time. Many are matters which can be fully satisfied by independent Armed Forces Medical Department action.

2. That the sources of information regarding things of military medical significance in most areas of the world are very sketchy and not current. That there should be a Medical Section established which should in peacetime seek out and keep current information as to the true status of all conditions which pertain to health and medical facilities in all foreign nations.

III. RECOMMENDATIONS

1. The establishment of a Medical Section in the Central Intelligence of the National Security Council composed of suitable experts to secure and have available in usable form Medical Intelligence of a global nature.

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF REPORT OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 Apr 48.

***** M. "One of the problems of paramount importance which was probably the most persistent problem during the war and which has continued throughout the past year is the matter of uniforms. No outdoor uniform was available in sufficient quantities at the beginning of the emergency to meet the needs of the rapidly expanding Army Nurse Corps. Nurses were brought into the service and assigned directly to existing operating hospitals, or were brought in through the affiliated units and assigned to installations for purposes of training prior to shipment overseas. That period of assignment to these various installations varied from two weeks to over a year. It wasn't until our basic training centers were set up in the latter part of 1943 that there were established centers from which we could equip nurses. So, up to that time, the uniform equipment for nurses, for women of the Medical Department, was on a mail-order basis. The first five thousand nurses that were brought into the service were handled through the Surgeon General's Office, and the sizes of clothing for these people were recorded by the Nursing Division. The list of sizes was submitted to the Quartermaster in the hope that they would use that as a basis for setting up their size requirements since the group of women that were being brought into the Medical Department were within a certain age group and had to meet certain physical requirements as to height and weight. Instead, I understand that the Quartermaster General's office used size tariffs supplied them by the National Silk and Suit Company, and the result was that they stocked many sizes that we couldn't use and there was a very great shortage of the necessary sizes and a great oversupply of the larger sizes.

The rapid movement of personnel overseas did not allow time for the necessary requisiting of clothing from the Quartermaster, then shipment to the post, and the equipment of nurses. So, I know from personal experience that many nurses went overseas with probably a scarf, a pair of gloves, and a few pieces of civilian clothing that they brought with them. It took months for our personnel to get their complete authorized uniform equipment, and many nurses were departed from the service after one or two years of service without ever having received their full authorized issue. Until a suitable uniform for tropical areas was made available, nurses in tropical areas were sweltering in winter uniforms; and, at the same time, nurses in Europe and Africa were suffering from lack of adequate warm clothing.

Our difficulties, as I say, have been right with us through this year, particularly in the supply of our hospital uniform. The sale of that uniform was not restricted to the personnel authorized and required to wear it. Consequently, in overseas areas and in some areas at home, civilian personnel could buy it, which would result in depleting the sizes our people needed. We found our nurses in very tattered uniform. We had to appeal to the Quartermaster and the PX to help straighten that situation out, to put in emergency requisitions, but I still find, when I make visits, that they are experiencing trouble. Now, with the authorization of a white uniform which will allow the nurses to purchase directly from civilian uniform companies as we did prior to the war during peacetime, it may take care of that situation.

It wasn't uncommon during the war to experience difficulty in obtaining proper shoes; and, when I was in the office during part of the emergency, I answered frequent calls from Congressmen and families wanting to know where they could get coupons to purchase shoes for their daughters overseas and wanted to know why the Army couldn't make those items available.

RESTRICTED

RESTRICTED

TRUE COPY (Extract Ltr Nellie Jane DeWitt, Captain (MC), USN, 29 April 1948).

*****A senior nurse corps officer should be assigned to each District to act in an advisory capacity to the District Medical Officer in matters pertaining to the nursing service of the District.

Rank distribution, and status of reserve nurses on inactive status should be considered carefully and equitably adjusted before an emergency arises. The number of Commanders and Lieutenant Commanders presently allowed is not adequate to cover the top nursing billets in naval hospitals now in operation. It is recommended that legislation be initiated now to remove the restrictions in the ranks of commander and lieutenant commander in the Regular Nurse Corps. Unless adjustment is made in the present rank structure a detailing and local administrative problem will result in the event of mobilization of reserves on inactive status. Under the system now prevailing nurses on inactive status in the reserve corps who have been issued permanent appointments in the rank of lieutenant commander, if assigned to active duty, would be senior in rank to regular nurse corps officers senior in service experience who reverted to the rank of lieutenant in accordance with the provisions of Public Laws #36 and #381. Another point to be considered is that those officers who reverted to the rank of lieutenant will be required to take a professional examination when they become eligible for promotion, whereas officers in the reserve corps will attain the rank of lieutenant commander without being required to take an examination.

At the present time the method of computing inactive service of members of the Naval Reserve Nurse Corps is at variance with the method followed by all other branches of the Navy (officer or enlisted personnel), for these nurses do not receive credit for inactive status when computing service for longevity and for pay purposes.

A legal advisor should be assigned to the Nurse Corps to advise the Director of the Corps in all matters of a legal or legislative character.

Nurses should be assigned to the professional duties for which their education and training have prepared them. In World War II nurses were assigned to duty in linen rooms, and as housekeepers and stenographers.

A list of nurses with special training, such as anesthetists, dietitians, operating-room nurses, etc, should be maintained in the Bureau of Medicine and Surgery and in each District, so that the service of these specialists in the Nurse Corps may be properly and advantageously utilized.

Because of the limited facilities available at Receiving, Evacuation and Convalescent Hospitals, it is recommended that such hospitals be used only for the purpose for which they are established." *****

RECEIVED
L K POHL
Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT OF REPORT OF INTERVIEW WITH COL MARY G. PHILLIPS, ANC, 27 Apr 48. CONT.

Misinformation as to the need of necessary equipment in overseas areas was sometimes given out at the port -- I don't know through whose fault -- so that some of our units sailed after items of uniform, such as raincoats and galeshes, were taken away from them. They would get overseas in the rain and mud without those necessary items, and the overseas theaters did not have the supply to take care of their needs.

Failure to restrict Post Exchange sale of women's items in overseas theaters to American women frequently caused depletion of such supplies and necessitated the women of the service requesting their families to send other necessary articles. Later on, while the nurses got overseas without being properly equipped, uniforms had to be shipped overseas to catch up with the nurses; but, of course, priority then had to be given to shipment of very necessary war supplies and the clothing very often was held at port waiting for a high enough priority.

In our matter of uniforms which was, as I said, one of our biggest problems, I think there are going to have to be centers of distribution set up.

REAR ADMIRAL ANDERSON: Do you recommend a uniform system of uniforms for all women in a given armed force?

COLONEL PHILLIPS: I surely do. The only difference should be in the professional uniform and the non-professional uniform so that the patients in the hospitals will know whether they have a professional person or one of the non-professional group. The WACS agree with that, too. But in other matters of uniform, the same, only different insignia. That would do away with our distribution problems.*****

RECORDED

L.I. POHL, Colonel, MC

RESTRICTED

RESTRICTED

EXTRACT OF STATEMENTS MADE BY CAPT. E.H. HERRING, JR., (MC) USM ON 22 APRIL 1948
AT INTERVIEW WITH SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL RESOURCES.

***** M. "This does not refer specifically to A-Bombs, but for any catastrophe we should have plans. For instance, in the area in which my station is located we have a few local plans. Last year we had two hurricane alerts, and I had my medical companies ready to go. But it was just local. There wasn't any authorisation for it or any back-up medical supplies other than our combat supplies which we normally have.

In a total war all of us should have definite plans as to what our utilisation in this country is going to be, rather than just over there in the target area." *****

RECORDED

L.F. FOHL, Colonel, MC

RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Captain M. J. Aston (MC), USN
Portsmouth, Virginia, dated 23 April 1948)

***** "As a medical officer of more than thirty-one years service I desire to state my belief that our nation confers no higher privilege on its citizens than to permit them to serve in its Armed Forces, as a career and most importantly during a time when the very existence of our country is at stake. I further consider that the overwhelming majority of the medical personnel of both army and navy served in this late war with complete fidelity and patriotism, and had little cause for discontent when the high privilege of such service was fully realized. It is perhaps inevitable that in times of peace our armed forces come in for a varying degree of criticism. Much of this criticism in my opinion is unwarranted, yet we are exposed to it and in order that it can be held to a minimum, it behooves us to put our house in order and to keep it in order, to the end that we may serve our nation more fully and effectively." *****



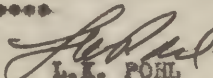
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY (Ltr Capt. E.P. Kunkel, MC, USN, dtd 21 Apr 48)

*****M. "The peacetime procurement of medical officers should be accomplished by the institution of armed forces medical schools. These schools could be located in large cities as Philadelphia, San Francisco, and etc. This type of school could be likened to Annapolis, except it would be a medical academy, so to speak, with the tuition and monthly salary paid by the government, and graduating the candidate as a lieutenant, junior grade, in the medical corps."*****


L.E. POHL
Colonel, MC

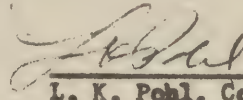
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter, Rear Admiral C. L. Andrus (MC) USN, 27 April 1948)

***** "It is also felt that since the Military Medical Resources (Army and Navy) in World War II were separately administered in accordance with different long standing regulations, policies, standards and practices of the respective services it is not possible to suggest certain corrective measures unless these basic concepts are reduced to a common denominator in so far as they can be made applicable to tasks and missions to be performed. With this accomplished it is believed that a single Medical Service would eliminate the cause of many controversial points and result in fewer reasons for criticism in regard to the Medical Service rendered our Armed Forces." *****

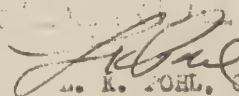
RECORDED



L. K. Pohl, Colonel, MC

TRUE EXTRACT COPY (Ltr Brig Gen Guy B. Denit, MC, Surgeon, 13 Apr 48)

***** M. "It is a mistake in my opinion to base our future plans on those plans and policies existing during World War II. That conflict is over and, although we may learn something from the mistakes of the past, we may be sure that the conditions of future warfare will be radically different from those pertaining during the past war. Future planning should be based on the visualization of conditions that will obtain rather than those that have obtained in past conflicts. It has been truly said that one thing that we learn from history is that we learn nothing. It appeared impossible to get some people in the Department of the Army to visualize the type of warfare fought in the Pacific. Our past and present teachings with reference to the medical service in theatres of war did not adequately cover the condition found in the Pacific campaigns. These campaigns consisted of island hopping across vast expanses of water with jungles as the ultimate beachheads. Similar conditions are apt to prevail in the future with a probability of substituting arctic conditions for jungle conditions. At any rate it is improbable that the entire campaign will consist of mass armies meeting mass armies in such numbers as have pertained in the European campaigns of World Wars I and II." *****



L. K. POHL, Colonel, MC

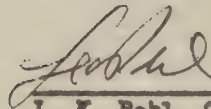
RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Dr. Wm. C. Menninger, Topeka, Kansas,
dated 22 April 1948)

***** "First, I want to be perhaps impertinent and strongly recommend to General Hawley through you the appointment of several civilians on your committee of coordination of these medical services. I do this with the sincere belief that some of the civilian medical confreres might have major contributions to make to your committee which could not and will not be brought out, in my opinion, when the committee is composed entirely of regular officers of the various Services. General Eisenhower repeatedly has indicated his belief that the military Services must include henceforth the active participation of civilians. To compose a committee of the medical officers of only the Services and to exclude the potential civilian members who become so important to you in a time of emergency, seems to me to be a lack of faith in these civilians and their potential contribution to the development of the military Services during "peace time". *****

***** "A minor point about court martials at which psychiatrists were supposed to appear. Long since we have recognized that if we are going to give testimony about an individual that this should be on the basis of a "Friend of the court" and not as a partisan witness. This still goes on unchanged. *****



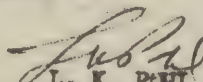
L. K. Pohl, Colonel, MC

RESTRICTED

RESTRICTED

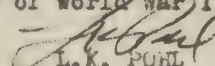
TRUE COPY (Extract Ltr James E. Hix, Lt Col., MC (Resigned) 11 April 1948)

*****I would rather plan for the future than to rehash alleged mistakes of the past about which little can be done, for as I see it the mission of the future will be different. Also, it would be unusual to have all the facts at hand which prompted any given policy or decision.*****


L. K. POHL
Colonel, MC

TRUE EXTRACT COPY (Ltr Brig Gen Guy B. Denit, MC, Surgeon, dtd 13 Apr 48)

***** M. "As stated in the beginning of this letter, these are random thoughts which occur to me as I dictate this letter. There is and can be no easy road to success in formulating future policies and plans for the Medical Department. Much research, careful study, vivid imagination, and persuasive arguments will be required before any gains can be made. One of the worst mistakes that we can make is to attempt to bolster up an old building with new props. It is essential that we start from the bottom, dig a firm foundation and build upon that a modern structure. I hope, as stated in your letter, that my remarks will not be construed as reflecting unfavorably against any individual or group of the military establishment and that they will be kept on a restricted basis. It is my opinion that the medical services of the Armed Forces did a superior job during the late war and were far above most of the other services. However, we do not now have and cannot in the very near future formulate plans as excellent for future conditions as those we had at the beginning of World War II. Time, experience, and thought will be required to bring our new plans up to the standards of those we had at the beginning of World War II."*****


L. K. POHL
Colonel, MC


RESTRICTED

RESTRICTED

TRUE COPY EXTRACT (Letter from Colonel Robert K. Simpson, USA (Ret.)
dated 1 May 1948)

**** "(3) As to suggestions with the end in view of attempting to remedy the defects previously noted: Universal military training in high school, premedical training and undergraduate medical education to build up a reserve of medical manpower. This solution depends upon what turn politics may take. Whether or not military training becomes compulsory, some system of obtaining trained and proficient physicians and surgeons for the "regular" or permanent Armed Forces must be considered. Medical education may be subsidized in several ways. Arrangement may be made with a recognized Medical School for the education of Doctors of Medicine to serve the Armed Forces, a kind of Medical Cadet Corps. These applicants may be selected from pre-medical training on a basis of scholastic record, physical standards, aptitude tests, etc., and sent through medical school at government expense, the course differing in no respect from the routine curriculum during the autumn, winter and spring months, but the summer months devoted entirely to military training and experience. Internships could be arranged in general hospitals. The trainees would be required to obligate themselves for a number of years service, certainly, at least, the number of years spent in training, perhaps more. Consider the cost of training an Air Force pilot in comparison with educating a physician. The expense of one year's flight training will probably exceed the five years training required for the physician. Professional and military training in emergency has been mentioned - specialized training at various centers, military or civilian, for the specialists, and special emphasis on camp hygiene, preventive medicine, sanitation, etc. for the young general practitioner, with a minimum of drill and military formations. As to enlisted personnel - train a man (or woman) for a certain job and insofar as possible, while he is in service, keep him on such a job. Promotion should be based on length of service and efficiency, primarily the latter, and not governed by rigid, iron bound tables of organization. In a period of emergency the original rank of the medical officer entering service should be governed by his age and professional experience. The base pay should be increased, to what extent I am not qualified to recommend, but at least it should be approximately the same for age groups, if practicable, of emergency officers. Staff assignments should be more "streamlined" and less professional talent utterly wasted on more or less meaningless desk jobs. Every echelon of command does not have to have a staff surgeon with a retinue of lesser lights, to help him "spin his wheels". Junior medical officers should be rotated from duty with combat organizations to hospital duty, and every encouragement offered to "keep on their toes" professionally." ****

RESTRICTED


L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel C. J. Baker, MC, Air Force
dated 22 April 1948)

***** "3. One other matter which I failed to comment upon previously, but which has been the cause of much disaffection is the methods of handling physical examination reports and hospital clinical records. It is my opinion that these reports and records should never be given to the individual concerned, but should be treated as 'Confidential' and forwarded through medical channels -- only recommendations affecting the status of individuals extracted and forwarded through military channels or given to the individual." *****

TRUE COPY EXTRACT (Letter, Brig. Gen. James Stevens Simmons, ME, USA (Ret.)
dated 30 April 1948)

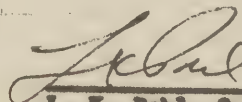
***** "However, I am writing to tell you how deeply interested I am in the planning by your Committee, and how important I feel it is to make adequate plans for military preventive medicine and civilian public health in connection with any total preparations set up by your group.

"I hope that such plans as are made for military and civilian health in the event of a new emergency will be worked out in such a way as to avoid the confusion due to shortage of specialized health personnel which occurred during the last war. As you know, this resulted in a wasteful competition among the Armed Services and civilian health agencies.

"While at the annual meeting of the Association of Schools of Public Health in Toronto on April 16, I was elected President for the coming year and was authorized by that Association to make contact with you and to tell you that the Association will be glad to cooperate with you and to assist your Committee in any way in which you think they might be useful. The Association is made up of the Deans of the nine accredited schools of public health in this country and one in Canada.

"I hope that during my stay in Washington I may have the pleasure of seeing you and discussing this matter further." *****

RESTRICTED



L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Captain F. C. Greaves (MC), USM
dated 17 April 1948)

"The memorandum on Deficiencies, Operational Errors and Misemployment of Medical Resources in World War II arrived 15 April. The request for comment and suggestions on the points mentioned will be difficult to comply with in the short time allowed and also in view of the fact that the validity of the criticism leveled against the Medical Services is questionable or, at least, requires considerable qualification. Certainly no criticism can be made against the results obtained by the Medical Services during World War II. The successful care, treatment and evacuation of casualties marks an all time high in the history of military medicine. The efficiency of preventive medicine practices accomplished by the Medical Services enabled commanders to successfully carry out military campaigns in some of the most disease ridden pest holes of the world."

TRUE COPY EXTRACT (Letter, Dr. Russel V. Lee, dated 18 April 1948)

***** "While not asked for, some considerations of civilian defense must be included in military planning. The likelihood of atomic warfare causing hundreds of thousands of civilian casualties is not fantastic. Airborne medical disaster teams should be organized immediately in all cities, prepared to fly with hospital equipment to any area subjected to bombing attack. Dry runs should be given these teams until they function smoothly. Medical students and pre-medical students must not be drafted. Associated scientific personnel should also be exempt -- except in the sense that every active medical man should be considered as part of the war effort and utilized accordingly."

RESTRICTED



L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT (Letter, Colonel Robert E. Peyton, MC, USA
dated 19 April 1948)

"****2. General. It is recognized that deficiencies in the employment of military medical resources did exist in World War II. A great mass of the reports of such conditions were undoubtedly in complete error. Only people at the proper range to observe and in possession of complete knowledge to properly evaluate their observations can be regarded as competent to judge many of the reported conditions. Further, it is neither fair nor sensible to confuse hindsight with foresight -- particularly when the information on which hindsight is based is prejudiced, incomplete, or other than that on which foresight is based.

"Much of the misunderstanding resulted from a failure to appreciate the dynamic situation in an active theater of operations. There is a constant inter-play of such factors as time, distance, dispersion, casualty rates, distribution of units, shipment of units, evacuation policies and the means used for evacuation, availability and priorities of unit equipment, availability and priorities on ground, surface, and air transportation, the acquisition and development of hospital plant sites, the necessity for the provision of reserves to meet either actual or anticipated needs, and ever changing strategical and tactical situations. Any one of these factors affects the others. The larger the theater and the faster the progress of military operations, the more important will these factors become. Provided the situation becomes static it is possible to approach ideal operating conditions, but even a static condition brings in its train many undesirable features; for example, the complaint that medical means are not being used to their capacity.

"***** In the theater where I served five American Armies were engaged in a combined operation, which, except for air participation, was initiated by an amphibious operation and progressed into a sustained war of movement on the continent of Europe. For the record, I think the Medical Department did a superior job. We exercised a degree of medical management never demanded of any men before us. In all sincerity I challenge any men after us to do better. I submit that apparent correction of some deficiencies of World War II may open the door wide to more serious deficiencies in the next war.

L. K. Pohl
RESTRICTED

L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT FROM AIR EVALUATION BOARD SWPA REPORT NO. 35. THE MEDICAL SUPPORT OF AIR WARFARE IN THE SOUTH AND SWPA FROM DEC 7, 1941 TO AUGUST 1945.

***** M. "The various diseases encountered in these theaters were responsible for the loss of many days of flying duty. Malaria was one of the outstanding health hazards to efficient air operations. An excellent system of malaria control was developed during the course of the war which markedly reduced the morbidity rate from this disease. The airplane spraying of insecticides, especially DDT, was an efficient method of controlling disease-bearing mosquitoes and flies. It was the consensus of interested personnel that even more effective results would have been obtained had a special unit been developed for this purpose. Inadequate medical intelligence resulted in the failure to take proper precautionary measures in a number of instances. The high morbidity rate from disease which resulted, seriously threatened planned operations. This was particularly true of malaria during the early days of the war and scrub typhus during 1944. Water and food borne diseases were extremely common in these theaters and because of the lack of training of all personnel in the basic principle of field sanitation, the number of man-days lost from flying was frequently excessive. Materials and supplies necessary to control the diseases encountered in these theaters were frequently lacking.*****

RECEIVED
[Signature]
L. K. POHL, COLONEL, MC

CONTINUED FROM ABOVE:

M. "The effectiveness of the Air Force medical services in keeping troops in fighting condition, in contrast to the Japanese, was one of the most important factors contributing to the defeat of the Japanese Air Force.

Medical Officers in lower echelons were required to spend a disproportionate share of their time in the preparation of reports.*****

RESTRICTED

RESTRICTED

TRUE EXTRACT COPY: (Extract of statements made by Colonel Thomas J. Hartford, MC, USA on 29 April 48 at interview with Subcommittee on the Employment of Military Medical Resources)

***** "n. Well, only one thing. I think that we should emphasize to the rest of the Army at every opportunity that aside from purely medical care that we should be in on the engineer medical team, or whatever you call it, and should be educated and available to give staff advice. I think the Navy is ahead of us on that, and I lay that to the fact that they have had some experience in working with the bomb.

The Army has made the decision that the Chemical Warfare Service will be responsible for developing the training and doctrine connected with radiological defense, and I am anxious that we be included in a rightful slot; not to build up any empire in that connection, but because I feel that we are the people, along with the engineers, best qualified to take an active part in it.

I have got very decided ideas on it. I think the idea is sound. We do need medical intelligence. We don't have it to any degree; but that's something that might be joint, and if it were joint we could get three times as much of it. I see no excuse in the world why it couldn't be joint, and I would like to see more emphasis placed on it, and it's easy to sell to the line. I have found that out with short experience.

I worked with them recently about a month on a particular problem and they are very happy to get it. They were a bit snug in the beginning that they had it, but when they realized they didn't, they were like they always are, very anxious to get it; and I think in addition to the people we put out that are purely professional people for some reason that it wouldn't be bad for the ground forces to concentrate on it a little bit, and if we could go together with the Air Force and Navy and give a little wider coverage, we can't have all the personnel out there/would like, but if we could get some ground force personnel out there so that some of the stuff that comes back is worth something to somebody that has to do planning to get ready for the next war, rather than some highly-specialized technical research that is important but doesn't help you too much with the planning.

I would also like to make a comment just to gig these boys a little bit that I argue with every day, that the only place we have any medical intelligent people are in the countries that we could send a radiogram and get all the stuff mailed to us in a nice envelope; and some of those countries that are perhaps not as desirable to live in, but in which we should have some information on, we don't have anyone.

I would like to have it so that the respective surgeons general could have some control over it because I think that they probably have the only people that could evaluate it. I think we should give evaluated intelligence probably to the central intelligence agency and let them distribute it to the services, but I think it should be evaluated intelligence; in other words, the complete product.

RESTRICTED

CONT'D

RESTRICTED

***** "M. I am not too well versed on this central intelligence agency--that is foreign intelligence, as I understand it, and that's what I am speaking of, foreign intelligence in counter-distinction to liaison and cooperation which I think we can get very easily. I don't call that intelligence, having a couple people over in London. I don't think that is intelligence. You can write and get all that stuff. It's desirable to have them there, I don't mean it's not, but I mean that isn't intelligence. *****

RECORDER

L. K. Pohl
L. K. Pohl
Colonel, MC

TRUE EXTRACT COPY OF MEDICAL SUPPORT OF THE USAAF IN THE EUROPEAN THEATER OF OPERATIONS. HISTORICAL SECTION - APTAS.

***** M. "Personally I feel that no medical officer as such serves any good purpose on combat missions and we therefore risk a critical item - the medical officer - for a very questionable gain. I do not know your reaction to this matter, however, if Flight Surgeons were not eligible for the Air Medal the combat mission problem would be a "dead duck".*****

L. K. Pohl
L. K. POHL, Colonel, MC

TRUE EXTRACT COPY (Ltr Cmdr Martin T. Macklin (MC) USN, dtd 12 May 48)

***** M. "It would be of advantage to standardise the records of all Armed Service personnel, officers and enlisted, with recommendations for the future considerations of the Veteran's Administration. This standardisation should also include reports, forms, requisitions, nomenclature, supply catalogs, equipment, etc.

It would be well for the services to establish a working plan for the Nurse Corps, whereby the individual's professional training is utilised for the bedside care and attention of patients - rather than expending most of their efforts in clerical work and non professional duties that could be performed by grey ladies or other competent workers. Such a plan would also not towards solving the enlisted personnel shortage.*****

RESTRICTED

L. K. Pohl
L. K. POHL, Colonel, MC

RESTRICTEDEXTRACT OF STATEMENTS MADE BY:Colonel Frederic B. Westervelt, MC, U.S.A. on 22 April 1943 at interview with Subcommittee on the Employment of Military Medical Resources

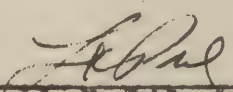
***** As far as atomic warfare is concerned, I can't answer that I guess any more than anybody else can. I understand that the general concept of planning for disaster relief within the continental limits considers at this moment that the major portion of disaster relief will be conducted by civilian agencies. Naturally they will look to and will need some type of military guidance and control, but the armed forces cannot be expected to have medical service for the armed forces and also take care of the civilian population, too. With that in mind I don't believe there will be any immediate or imminent change in our planning."*****

"(M) 10. As far as No. 10 is concerned, I think the armed service medical departments on the very highest level should participate in planning for civil defense because even though civil defense I think properly belongs with the civilians, nevertheless they are going to look to the military for guidance and they are going to have to be given that guidance by the military."*****

"(M) 19. I agree with 19. I think that we definitely need a medical intelligence agency. It was certainly demonstrated in the recent war that we needed this information, we needed it badly. I think it should be kept up to date at all times. I don't know what organization in particular would be most practical, but we certainly need some organization."*****

"What is your opinion of the advisability of establishing a joint armed forces agency or institution to collect, evaluate, publish, and disseminate the results of past and current research and development in the fields of military medicine and surgery and preventive medicine, including atomic warfare, biological warfare, and psychological warfare?"*****

"I think that's an excellent idea also. I think that the advantage of training individuals, and further by furnishing trained individuals for future staff use and indoctrination would be tremendous. I also think that the very fact that the institution itself was conducting teaching would keep up their standards and keep them on a much higher level by virtue of the fact they not only were doing this work, but were imparting this information to other people in a student capacity."*****

RESTRICTED

 L. K. Pohl, Colonel, MC

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH COLONEL VIRGIL CORNELL, MC, USA, 30 APRIL 1948

***** M. "I would like to ask your opinion as to whether the atomic warfare, which seems destined to occur in wars of the future, will increase our total medical requirements and if we need any special units for this possibility?

COLONEL CORNELL: You mean particularly Army units in the field or general throughout the nation?

BRIGADIER GENERAL MARTIN: In the field particularly.

COLONEL CORNELL: It hasn't occurred to me that it would pay to use the atom bomb on forward units to any great extent. It might be used over huge ports of embarkation, debarkation, supply depots, ordnance depots, large airports, or something of that sort where a whole group of bombers could be put out over night, so that only at those points would I think that the thing had to be considered.

It would be of no value to have a special unit there because we wouldn't have them after the atom bomb exploded. I think that is one of our greatest dangers. Our medical installations, which will be greatly needed after the atom bomb, should not be where the atom bomb may explode. They should be at least five, perhaps better seven miles beyond what might be a center.

That's one of the reasons I have considered the building of these big new hospitals down town in Washington are rather poorly chosen sites. I don't know that a special team is needed because after all it isn't the radiation effect which we are going to be able to do anything for immediately on the persons who are exposed. The greatest need is going to be in preventing people from coming in contact with radiated substances.

I think one of our biggest difficulties, especially with regard to our blood program, is to be able to have the intestinal fortitude to say that this fellow shouldn't get any blood because it won't do him any good. Let's give it to somebody else that needs it more.

COLONEL POHL: The same applies with your penicillin and these other items, wouldn't it, as to their blood count level; I believe the concept is if it gets below a certain stage there is no use in giving them blood, and if you have a short supply of infection preventing anti-biotics you are going to have to make a distinction. Now, how will these distinctions be made? What teams do we have?

COLONEL CORNELL: Yes, but I don't know how our supply of streptomycin might be at those times. I think we can increase production of them, but blood is just something you can get so much of at a given time and will have just so much on hand. Of course if your stock of anything critical has been decreased that's needed in this whole group of patients, then you have to decide which group have a change and which group do not; but I do believe from the - you might call it sanitary aspect, broadening the subject of sanitation to radioactive materials now, your water supplies, even your buildings and material and supply dumps, food - I don't think will be so much affected unless it has been rained on by radioactive water and in all-metal containers - but those can be checked over by trained technicians, and that would seem to me would be sufficient. You wouldn't need a medical officer. What you need is a physicist in charge of such a team.*****

RESTRICTED

L. K. Pohl
L. K. POHL, COLONEL, MC

RESTRICTED

TRUE COPY EXTRACT OF INTERVIEW WITH REAR ADMIRAL MORTON D. WILLCUTTS (MC) USN
ON 4 May 1948

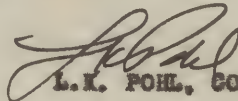
***** M. "Rear Admiral Anderson: The work of the Subcommittee on Employment of Military Medical Resources is outlined in this letter you received from the Executive Secretary of the Committee on Medical and Hospital Services of the Armed Forces. On the list of subjects given in paragraph 3 are those that we have asked to review and offer recommendations that might improve the medical services. We are interested particularly in improvements where experience in the last war indicated that changes in organization, training, logistic supply, or other parts of the medical service might be improved.

Do you care first to make a statement following this outline? Do you care to comment on it without questions, first?

REAR ADMIRAL WILLCUTTS: My comment, Admiral Anderson, first, would be that personally I was very much impressed with the efficiency of the Medical Department of the Navy. I saw no deficiencies that could not be explained on the basis of war, which, as we all know, is always wasteful. Wasn't it General Forrest who said that victory goes to the one who gets there fastest with the mostest?

Your subject startled me -- deficiencies, operational errors and misemployment of military medical resources in World War II. I understand that is a broad subject. I am merely commenting that personally I refute that as a specific charge against the Armed Forces, especially with the one I am acquainted with.

I do not think there are deficiencies. There were errors, there was misemployment of military resources. Why? Because we were at war. I have no rebuttal or excuses to explain it away.*****


L.K. FOEHL, COLONEL, MC

RESTRICTED

COMMITTEE ON MEDICAL AND HOSPITAL SERVICES
OF THE ARMED FORCES

REPORT OF COORDINATION MEETING

Between

Members of Subcommittee on Medical Research

and

Members of Subcommittee on Employment of Military
Medical Resources

5 May 1948

RESTRICTED

1. This meeting was held at 1415, May 5, 1948, in accordance with provisions of Letter, Committee on Medical and Hospital Services of the Armed Forces, Subject: Coordination Among Subcommittees, and Presentation of Subcommittee Reports, dated April 27, 1948.

2. Officers present were Brigadier General Joseph Martin, MC, Colonel Otis O. Benson, MC, and Colonel L. K. Pohl, MC.

3. The precepts and terms of reference being considered by the two Subcommittees were reviewed.

4. The following discussion was recorded:

"COLONEL BENSON: This is on research, and it's certainly my opinion from attending subcommittee meetings on research that there would seem to be rather complete agreement that the directorships and the direction of research in the respective medical services should remain in their present forms and status.

"Some of the considerations leading to this apparent conclusion are:

"1. That each of the research directors under the respective Surgeons General and Air Surgeon, with their small staffs, act as day-by-day consultants to their chief and to innumerable military officers of their department, and act as consultants and informants to many civilians and university agencies.

"2. That basic research cannot truly be duplicated, and it would even be desirable if more and more fundamental researches were duplicated prior to announcement of the result to insure complete factuality and truthness of concept.

"3. The Subcommittee would also seem to agree that much closer liaison and coordination must be effected in the field of medical developments.

"4. A final and very conclusive consideration is that established by law is the Research and Development Board existing at the level of the Secretary of Defense. Its legal terms of reference set this Board up as the Research and Development Coordinating Agency for the Armed Forces.

"In the medical field, in its broadest sense, are two committees, first, the Committee on Medical Sciences, and two, so that this is a contiguous and related field, the Committee of Human Resources. Thus it is

RESTRICTED

RESTRICTED

apparent that R&D Board is and will be the Research and Development Coordinating Agency despite any contrary opinions expressed by military personnel concerned with research.*

. . . OFF THE RECORD . . .

5. The following conclusions and agreements were reached as a result of this meeting:

a. The Subcommittee for Employment of Military Medical Resources has no overlapping findings, conclusions or recommendations which may be considered in conflict with those being considered and/or planned for recommendation by the Subcommittee on Medical Research.

b. Both Subcommittees are in agreement that need exists for a central collection, assembly and disseminating agency for the instruction of military and civilian (particularly potential military) medical professional personnel, of research findings and data of common interest. This is believed particularly desirable so as to lessen preliminary training and instructional periods required for Medical Department personnel upon mobilization and to increase their potential efficiency in event of need for their services in either military or civilian status in event of total war on this continent.

RESTRICTED

RESTRICTED

COMMITTEE ON MEDICAL AND HOSPITAL SERVICES
OF THE ARMED FORCES

REPORT OF COORDINATION MEETING

Between

Members of Subcommittee on Medical Intelligence

and

Members of Subcommittee on Employment of Military
Medical Resources

5 May 1948

RESTRICTED

RESTRICTED

1. This meeting was held at 1330, May 5, 1948 in accordance with the provisions of Letter, Committee on Medical and Hospital Services of the Armed Forces, Subject: Coordination Among Subcommittees, and Presentation of Subcommittee Reports, dated April 27, 1948.
2. Officers present were Brigadier General Joseph Martin, MC, Colonel Otis O. Benson, MC, and Colonel L. K. Pohl, MC.
3. The precepts and terms of reference being considered by the two subcommittees were reviewed.
4. The following discussion was recorded:

"COLONEL BENSON: The Subcommittee on Intelligence have completed their deliberations and have agreed on recommendations. The final report has not been submitted to the parent committee, but the recommendations are quoted by virtue of the subcommittee agreement concerning them.

"RECOMMENDATIONS:

'1. That an Armed Forces Central Medical Intelligence Organization be established.

'2. a. That this Central Medical Intelligence Organization be centralized by a Medical Intelligence Office assigned to and operated under the Medical Coordinating Board at the level of the Secretary of Defense.

'b. Alternate recommendation: If a Medical Coordinating Board is not established, that the Central Medical Intelligence Organization be constituted similar to the organizational relationships of the Army-Navy medical procurement office.

'3. That the Central Medical Intelligence Organization be budgeted by the Secretary of Defense or, as an alternate proposal, that the three services contribute to its financial support.

'4. That the Director of the Central Medical Intelligence Organization be a medical officer from one of the services and that he be selected by the Medical Coordinating Board; that the military staffing be on a tri-partite basis.

'5. That the mission of the Central Medical Intelligence Organization be as follows: To render such medical intelligence service as may be required by each department of the Armed Forces and to other accredited agencies.

RESTRICTED

RESTRICTED

'6. That the Central Medical Intelligence Organization stimulate and make greater use of the material currently being collected by numerous individuals, missions, and organizations both within and without the Government structure; that the Organization be given authority to send abroad special observers or missions for the collection of information; that medical attaches be authorized in sufficient numbers and locations to assure essential coverage; that medical personnel assigned to special military missions abroad be given an intelligence assignment as part of their over-all duties in the foreign station; that ALL attaches from the three departments be briefed by the Central Medical Intelligence Organization prior to assuming duties abroad.

'7. That a permanent and enduring relationship between the Central Medical Intelligence Organization and the Central Intelligence Agency be established on a formal basis by directive; that the Central Intelligence Agency be requested to perform certain special missions.

'8. That the Central Medical Intelligence Organization study both the peace and mobilization (war) 'job' and training requirements of the medical services for medical intelligence; that the Organization assume a dominant role in advising these respective medical services on these considerations.'

. . . OFF THE RECORD . . .

"COLONEL POHL: Are there any factors in the subjects listed for consideration by the Subcommittee on Medical Resources which should be brought to the attention of that Subcommittee as of interest to members of the Subcommittee on Medical Intelligence?

"COLONEL BENSON: I believe in our report one place and another that we have covered the difficulties, growing pains, lack of foresight, and all that type of thing, impetus by virtue of size and command position, medical intelligence. I think in the final and completed document that we will submit that it would have been covered."

. . . OFF THE RECORD . . .

5. The following conclusions and agreements were reached as a result of this meeting:

a. The Subcommittee for Employment of Military Medical Resources has no overlapping findings, conclusions or recommendations which may be considered in conflict with those being considered and/or planned for recommendation by the Subcommittee on Medical Intelligence.

b. The Subcommittee on Employment of Military Medical Resources has decided that the establishment of a medical intelligence agency as a source of global medical information is a very necessary and immediate step forward in national defense. Such is recommended for action by the Committee on Medical and Hospital Services to the Secretary of Defense.

RESTRICTED

RESTRICTED

OFFICE OF THE SECRETARY OF DEFENSE
SUBCOMMITTEE ON THE EMPLOYMENT OF
MILITARY MEDICAL RESOURCES

Tuesday, 11 May 1948 - Room 3D675 - 1:30 p.m.

In Attendance:

Rear Admiral T. C. Anderson (MC), USN, Chairman
Brigadier General Jos. I. Martin, MC, USA, Member
Colonel Louis K. Pohl, MC, USAF, Member

Appearing:

Colonel W. D. Graham, MC, USA
Subcommittee on Medical Services for Dependents

RESTRICTED

RESTRICTED

. . . The meeting convened at 1:30 a.m., with Rear Admiral Anderson presiding . . .

ADMIRAL ANDERSON: Our Subcommittee has been directed to confer with representatives of other Subcommittees of the Hawley Board on subjects whose consideration concern both Committees in order that our conclusions and recommendations will be in line. Your Subcommittee is on Medical Services for Dependents, I believe. We have referred to the care of dependents in some of our discussions, particularly in connection with hospitalization in the Zone of the Interior *** during national emergency. We would be interested in knowing what conclusions, recommendations, or opinions your Subcommittee has concerning care of dependents during another war.

COLONEL GRAHAM: We had not specifically considered it, although P & O have discussed it. We have not made any recommendations, nor did we know we were supposed to. We thought that would be your job. We would have to place the restrictions on dependent medical care to the limit that they were placed in the last war, which was that no additional facilities could be made available and dependents would be more rigidly excluded than they had been in peacetime. Some stations took care of them all during the war. The decision should be a local commander's decision, probably based on the recommendation of his chief medical officer. One thing that should be brought back into operation would be the program known as the Emergency Maternal and

RESTRICTED

RESTRICTED

Infant Care Program, which would now be in Federal Security Agency, which provided for obstetrical and care of infants up to one year for soldiers and sailors of the lower four grades. It was presumed that the majority were inducted into the service and therefore their hardship would be greater than hardship of those in a higher pay bracket. Congress passed a law giving funds for that job which was administered out of the Childrens Bureau of the Department of Labor and they used not only civilian medical agencies and hospitals but also military hospitals and there was a reimbursement made in the case of federal medical facilities being used. The Childrens Bureau downgraded the authority to the State Health Departments to spend the funds allocated to the states by them. I don't know if that is specifically tied up with armed forces but certainly the idea should be pursued.

GENERAL MARTIN: Do you consider in the situation that might arise in the United States in any future war whether or not provisions for dependent care would be more necessary as a result of atomic warfare?

COLONEL GRAMAM: I would like to answer that by saying it requires two answers. The first is that the static care of dependents should be downgraded similar to that in the former war and how many dependents we actually have will depend on the size of the Army and where the Army is. Static care of dependents should

RESTRICTED

RESTRICTED

be offloaded from the medical resources of the military. In the event of a catastrophe there has to be an overall plan which will use the pool of hospital beds remaining no matter who owns them, supports them, or staffs them.

GENERAL MARTIN: Would you recommend at this time to ask for additional medical resources in the military services for the care of dependents?

COLONEL GRAHAM: No, Sir.

ADMIRAL ANDERSON: It seems the problem now that in the case of another national emergency that medical manpower will be more critical than during the last war. The question of the care of dependents then as to whether it shall be done by the military services or by civilians goes back to whether there is enough medical talent to look after them. It has a bearing in this way. That there will be a much more critical scarcity of physicians if they are called into the service, at least as far as number is concerned, during the next emergency. It should be taken into consideration with the National Security and Resources Board. They have to have care. If it is to be done by the military a proportional number of physicians and medical supplies must be allocated to the military services for that purpose. In our service, at least, the care of dependents was a great morale factor with our personnel. The men overseas received comfort from the knowledge that in the case of sickness they would be looked after. Would that

RESTRICTED

RESTRICTED

modify your idea of offloading as far as possible?

COLONEL GRAHAM: If we keep talking about total war, which we do, we must then talk about a practical means of total mobilization of medical and other means. If we would be able to have a total mobilization of means, including medical, then definitely the military medical group should not be loaded with the care of dependents, but the otherwise mobilized medical means should have that job. *** I don't think it is well to take care of them during wartime.

GENERAL MARTIN: The Committee has taken due cognizance of many complaints by reserve officers who served during the war and most of their time in particular cases, and a great deal of their time in other cases, was spent in caring for dependents of military personnel. Can we better that condition and prevent disaffection in the future?

COLONEL GRAHAM: I don't know whether we can, but one way we can is to withdraw the advantages of civilian practice during war from the medical profession so that they too are mobilized.

COLONEL POHL: We have considerable complaint in regard to these in regard to disaffection - particularly dentists. I think it is a problem we are going to have to come up with some solution.

ADMIRAL ANDERSON: What is the conclusion of your Subcommittee with regard to the care of dependents during peacetime. Should the service be expanded to include dependents?

RESTRICTED

RESTRICTED

COLONEL GRAHAM: From the standpoint of the Medical Corps as a career it is extremely valuable to have dependents as patients because then you get patients from all age groups with all types of conditions. From the standpoint of the service the care of dependents makes better doctors. From the standpoint of the service the care of dependents improves morale, is an intangible monument to the low salary of service personnel. Dependent care is authorized by law. Dependent care should be extended to the full resources available and that can be secured. It is impossible for us to ignore the fact that everywhere any of us in the Committee has ever visited the first complaint is - "I need an obstetrician, pediatrician, etc." If we had other than doctors in sufficient number - that would be nurses and ward attendants - for women and children, I think that the doctors could stretch. *** We could get along with the doctors we have if the budget could get us more maids, etc.

. . . The meeting adjourned at 2:00 a.m. . . .

RESTRICTED

RESTRICTED

OFFICE OF THE SECRETARY OF DEFENSE
SUBCOMMITTEE ON THE EMPLOYMENT OF
MILITARY MEDICAL RESOURCES

Tuesday, 11 May 1948 - Room 3D675 - 2:30 p.m.

In Attendances:

Rear Admiral T. C. Anderson (MC) USN, Chairman
Brigadier General J. I. Martin, MC, USA, Member
Colonel Louis K. Pohl, MC, USAF, Member

Appearing:

Brigadier General Silas B. Hays, MC, USA
Major John Luft, MSC, USA
Subcommittee on Medical Supply

. . . The meeting convened at 2:30 p.m., with Rear Admiral Anderson presiding . . .

ADMIRAL ANDERSON: We have the subject of medical logistics in military campaigns to study and report upon.

GENERAL HAYS: The Subcommittee on Medical Supply of the Armed Forces did not consider the logistical support in the Theatre of Operations. Our Committee report did include a statement that one medical supply service overseas was desirable for wholesale distribution.

ADMIRAL ANDERSON: How would the one medical supply service be operated?

GENERAL HAYS: We recommended that wholesale distribution of medical supplies be under the Theatre Commander.

ADMIRAL ANDERSON: He would select the particular service that was to operate?

GENERAL HAYS: Or could set up a joint one if he so desired.

. . . The meeting adjourned at 2:35 p.m. . . .

RESTRICTED

RESTRICTED

**SUBCOMMITTEE ON THE EMPLOYMENT OF MILITARY MEDICAL
RESOURCES**

Wednesday, 12 May 1948, Room 3D-676 - 1:30 P.M.

In Attendance:

**Rear Admiral T.C. Anderson (MC) USN, Chairman
Brigadier General J. I. Martin, MC, USA, Member
Colonel Louis K. Pohl, MC, USAF, Member**

Appearing:

**Brigadier General Harry G. Armstrong, MC,
Subcommittee on Aviation Medicine**

**.....The meeting convened at 1:30 P.M., with Rear Admiral
Anderson presiding.**

**Agreement was reached that the Subcommittee on Aviation
Medicine would make representation relative to developments of im-
proved techniques in the accomplishment of air transport of sick
and wounded for the Armed Forces. Further, it was agreed that the
Subcommittee on Employment of Military Medical Resources would con-
sider tactical concepts and requirements for air evacuation.**

RESTRICTED

RESTRICTED

The NATIONAL MILITARY ESTABLISHMENT

OFFICE OF THE SECRETARY OF DEFENSE

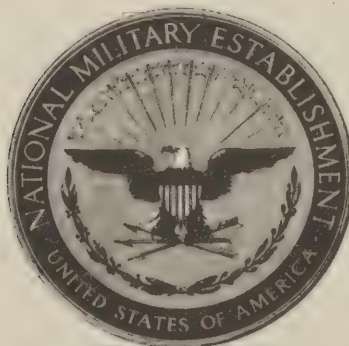
SUBCOMMITTEE ON THE EMPLOYMENT OF

MILITARY MEDICAL RESOURCES

7 May 1948 - 1:30 p.m. - Room 3D675

Appearing: Major General T. L. Smith, DC, USA
Rear Admiral C. V. Rault, DC, USN
Brigadier General G. R. Kennebeck, DC, USAF

WASHINGTON, D. C.



RESTRICTED

818

NO. 203

Conference Reporting Section
Reported By: R. P. Wag.
Extension 5167 Room 3C717

(COPY 4)

RESTRICTED

OFFICE OF THE SECRETARY OF DEFENSE
SUBCOMMITTEE ON THE EMPLOYMENT OF
MILITARY MEDICAL RESOURCES

7 May 1948 - 1:30 p.m. - Room 3D675

In Attendance:

Rear Admiral T. C. Anderson, MC, USN, Chairman
Brigadier General J. I. Martin, MC, USA, Member
Colonel L. K. Pohl, MC, USAF, Member

Appearing:

Subcommittee on Dental Matters

Major General T. L. Smith, DC, USA, Chairman
Rear Admiral C. V. Rault, DC, USN, Member
Brigadier General G. R. Kernebeck, DC, USAF, Member

RESTRICTED

. . . The meeting of the Subcommittee on the Employment of Military Medical Resources convened at 1:30 p.m., 7 May 1948, in Room 3D675, with Rear Admiral T. C. Anderson presiding . . .

REAR ADMIRAL ANDERSON: I think the quickest way is to take up those subjects where there is overlapping. Then, after we have discussed those, if there are some other subjects on our agenda that General Smith might wish to comment on, we can accept those. But the first subject that we have listed here as one in which both of our subcommittees are interested is this classification and mobilization of medical manpower for the armed forces.

Now, I might say very briefly that our Subcommittee, in discussing classification, feel that an accurate classification record in the Surgeon General's office, the Chief of Medicine and Surgery's office, and the Air Surgeon's office, an actual classification record of each officer of the medical department, is necessary for assignment. We must know what his qualifications are and various details concerning the officer before you can assign him properly. We feel that this classification should be uniform in the three services. We feel that the present Army system is a very good one. It may be subject to some modification;

RESTRICTED

RESTRICTED

but, insofar as professional qualifications are concerned, it gives the officer's specialty and grades him in that specialty, whether he is nationally known, of the A classification, B, C, D, etc.

In regard to mobilization, our Subcommittee feel that the services should continue to maintain their reserve organizations and that the reserve officers would probably be called into service early in case of an emergency, but that, in order to procure medical officers and dental officers in addition to those in the reserve, they should be obtained through a national registry which would be maintained through the Selective Service system. There are some details about the actual mechanics of procurement after we have a national registry, but I don't believe those have to enter into it. What we are interested in knowing is whether your subcommittee has discussed these matters and are in agreement with those ideas.

MAJOR GENERAL SMITH: I certainly am in agreement with everything that has transpired here on that of the national registry and having it conducted by the Selective Service; that is, supervised by the Selective Service.

REAR ADMIRAL RAULT: I would like to add, if I may, that I don't think the Selective Service is the place to handle it. I think that's a wartime agency, and I

RESTRICTED

RESTRICTED

think the National Security Resources Board on the level which reports to the President would be better than Selective Service because Selective Service may go out of business after any war -- after any emergency. Certainly, medical manpower of the country is a national resource.

BRIGADIER GENERAL MARTIN: I might clear the entire matter up by asking you if you favor some national agency to control this matter.

REAR ADMIRAL BAULT: Positively.

REAR ADMIRAL ANDERSON: Next here is professional and military emergency training programs within the armed forces.

REAR ADMIRAL BAULT: May I ask something? How are we going to classify people? Do you have a code already in the Army? We have talked this over informally. I have never seen it. I know it's A, B, C, D. I mean, how do you determine who falls into each classification?

BRIGADIER GENERAL MARTIN: That's based upon the demonstrated ability and records of the individual concerned.

REAR ADMIRAL BAULT: Is there an outline of those requirements in existence?

BRIGADIER GENERAL MARTIN: There is.

May I ask you this question, which is the one involved: do you favor a uniform system of classification of

RESTRICTED

RESTRICTED

all medical resources within the three services?

REAR ADMIRAL RAULT: Certainly.

BRIGADIER GENERAL MARTIN: That's the question involved. As to its type, we have no definite opinion at the present time as to what it should be.

REAR ADMIRAL RAULT: I am in favor of it, to answer your question.

REAR ADMIRAL ANDERSON: To go on to (b), then, unless there are some other questions or comments.

Our Subcommittee have been concerned with training, not as to the particular subjects of training, but where and how it should be done. We have considered how senior medical officers could be qualified for staff duty. One difficulty encountered during the last war, I know from experience in the Pacific, is the fact that officers were assigned responsible places on the staffs of commanders without suitable previous training. The question comes up: how can a sufficient number of medical officers receive the training necessary to qualify them for staff duty? Then, we have discussed what training is necessary for specialists, men already qualified in their specialties.

The third feature of training is: what training is necessary for officers who are to be assigned to units in the field? There was a good deal of complaint from

RESTRICTED

RESTRICTED

discharged medical officers about the length of time they spent in camps engaged in military training of personnel and in receiving training themselves. We have felt that medical officers should be called into the service as late as is practicable in order to receive the necessary training for work with units in the field in an effort to avoid long duty in camps where they become dissatisfied. I think these are staff officers, specialists, and staff officers for duty with troops.

Are there other things about this training program?

BRIGADIER GENERAL MARTIN: We are concerned here particularly with the dental group, and I would like some discussion, if you have thought about it or considered it, as to what you would recommend for military training necessary for dental officers called during a mobilization without prior service in one of the armed services. First, do you believe that it is necessary?

BRIGADIER GENERAL KENNEDY: I don't believe it is necessary.

MAJOR GENERAL SMITH: We haven't discussed that at all. We have not gone into it. When this committee was called over, my reaction was that you could get it individually, if you like. My reaction would be that very little training for the professional men would be necessary.

RESTRICTED

RESTRICTED

For men who have had no service, the younger group particularly, should have some field training, coordination, or orientation. That, we haven't discussed up to this time. But I think they should have some training.

BRIGADIER GENERAL MARTIN: The next question is: do you consider any professional training necessary to men without prior military service for military dentistry and naval dentistry.

MAJOR GENERAL SMITH: If I might qualify that -- in certain phases of oral surgery, I would say, in war injuries. They haven't had any.

BRIGADIER GENERAL MARTIN: How long would you say?

MAJOR GENERAL SMITH: Three months.

BRIGADIER GENERAL MARTIN: Should all be trained in that specialty or just certain selected individuals?

MAJOR GENERAL SMITH: Only certain specialties -- certain selected individuals or where they would be dealing with that particular specialty. The others I think not. Any disagreement?

BRIGADIER GENERAL KISNERECK: I don't disagree. I think that, in the last war, some of our younger officers felt that the military training, strictly military, was not too useful to them; and, if we can keep that to the very minimum --

RESTRICTED

RESTRICTED

BRIGADIER GENERAL MARTIN: Has your Committee --

REAR ADMIRAL RAULT: I would like to answer the military question, first.

I believe that our officers should get some military training. In the past war, we in the medical department in the Navy tried to train them ourselves. I am inclined to believe they would do better if they were trained in line camps. That was done for all the staff officers in the Navy except medical and dental officers, and I got the impression that they had better basic training than we were able to give or were equipped to give. I am inclined to believe that those things should be done within each service because duties aboard ship, sanitation and other things might be different than they would be in the Army in the field.

REAR ADMIRAL ANDERSON: For how long a period should a dental officer be trained?

REAR ADMIRAL RAULT: I believe two weeks.

Now the professional services -- that would include all the sanitation, and so forth, and have nothing to do directly with the military. I believe they should get some training. As to the length of it, the General suggested three months, and it's probably correct.

MAJOR GENERAL SMITH: Professional training.

RESTRICTED

RESTRICTED

REAR ADMIRAL RAULT: Excuse me -- professional training for specialists. I think that may be a little long in an emergency, and for certain groups, perhaps, three months would be desirable and in others lesser time would be necessary because those people, in addition to getting professional training, would have to be familiarized with our forms and clerical procedure which is necessary even in war.

BRIGADIER GENERAL MARTIN: I would like to ask one more question. Do you favor the subsidization of dental students during a mobilization or war?

MAJOR GENERAL SMITH: If I may answer for the Committee on that, that has been discussed, and there has been no agreement as a Committee.

BRIGADIER GENERAL KENNEDY: What do you mean by "subsidy?" They are advised to give a certain amount of service after being deferred while undergoing dental training?

BRIGADIER GENERAL MARTIN: Comparable to the ASTP invoked during World War II.

MAJOR GENERAL SMITH: I am in favor of some such program, but not quite as extensive. There is no full agreement by the Committee. It hasn't been in full agreement as to what it is. They have discussed it at length,

RESTRICTED

✱
RESTRICTED

but we have no committee agreement on that.

REAR ADMIRAL BAULT: We haven't brought it up formally.

BRIGADIER GENERAL KENNEDY: How about the training of reserve officers in peacetime, the training of the officers we now have? We are talking so far about when an emergency arises. How about the training now of our present reserves?

REAR ADMIRAL ANDERSON: Our Subcommittee is interested primarily in training for emergency.

BRIGADIER GENERAL KENNEDY: This would be training for emergency of the reserve officers we now have. I mean to keep their interest up and keep the reserve going. They have to partially train people without any training and make them ready when the emergency arises. Has that been discussed from a medical angle?

REAR ADMIRAL ANDERSON: I don't believe we discussed at all what training should be provided for reserve organizations, have we?

COLONEL POHL: No.

BRIGADIER GENERAL KENNEDY: Not organizations, particularly the individual reserve, such as fourteen days.

COLONEL POHL: No period of active duty. We have discussed the setting up of a central agency for the

RESTRICTED

RESTRICTED

collection of material of common interest and setting it up on a training program with the possible thought of expanding that further later to having courses which they would attend at such an agency.

BRIGADIER GENERAL KENNEDY: Has extension work been discussed other than active duty for the interest of the reserve?

REAR ADMIRAL ANDERSON: We have had comments for and against. Some officers have felt that ordinarily a correspondence course -- that is what you referred to -- doesn't get you very far.

BRIGADIER GENERAL KENNEDY: It didn't help our dental officers a great deal in the past, from my opinion, in the correspondence courses, but the active duty training is another thing.

COLONEL POHL: I think the majority of opinion is against the extension courses as we have them available.

REAR ADMIRAL ANDERSON: This Subcommittee have discussed the proposal to organize what might be called a Medical Institute. That would be a group of competent civilian and medical officers, preferably, I think, a joint undertaking, which would assemble information, old and new, including research and advances concerning military medical treatment. They would present it in a form

RESTRICTED

RESTRICTED

that would be easy to refer to and be for the benefit of both regular and inducted medical officers -- a reference publication, as a looseleaf publication that can be modified from time to time, to which we could refer for quick reference, particularly in the field where libraries, etc., are not available.

BRIGADIER GENERAL KENNEDY: I had in mind expanded schools, modified for the reserve. It would be a big morale booster if dental officers, for instance, in the reserve should get a short course now and then at the Army Dental School. It would certainly sell him things that he isn't sold on now.

REAR ADMIRAL ANDERSON: We have included such an idea, that such an institute would not only publish concrete material, including research advances, in each of the special subjects that concern medical and dental officers, but also might be expanded to include resident courses for reserve officers.

REAR ADMIRAL BAULT: We now conduct such courses for the Naval Reserve at the Naval Dental School in Bethesda. We give them two-week courses, take about fifty or sixty in the courses at one time, and hold the courses quarterly. Each District fills a quota which we assign on the number of dental officers in the reserve in the District. Incidentally,

RESTRICTED

RESTRICTED

we have more requests than we can fill for the course, showing that it is popular with the people.

REAR ADMIRAL ANDERSON: It is very encouraging when you think of the reaction to the extension courses.

REAR ADMIRAL RAULT: The correspondence courses, as General Kennebeck points out, have been very unpopular, and I know that the Navy is engaged at the present time in writing similar courses. I look with a good deal of apprehension on their getting into the field and people trying to resign because I think there are 200 hours of work that they have to do on them; and, in the past, I know that these reserve groups got one person to write the answers to the course, and the rest of them all copied them and sent them in.

BRIGADIER GENERAL KENNEBECK: I used to be an instructor for one of those courses in dentistry. In a 100 hours, there was an hour or two of interest to the particular dentist. It was medical sanitation, problems in evacuation, and map reading, all rather foreign to what the dentist is going to do when he comes into the service.

. . . Off the record . . .

REAR ADMIRAL ANDERSON: The next subject is replacement pools of medical department personnel. We have included this as a matter for discussion with your Subcommittee

RESTRICTED

RESTRICTED

because of complaints that have been made by discharged officers of idleness and waste of talent while held in a replacement pool awaiting assignment. Some source of replacement of officers in service is necessary, and the problem is how to have available a reserve supply of officers without having them idle and dissatisfied in some replacement pool.

REAR ADMIRAL RAULT: I was not aware of any replacement pools that the Navy had in that fashion. You may know more about that being out in that forward area in the Pacific, or General Smith in the European Theater.

MAJOR GENERAL SMITH: Replacement pools per se, as they are commonly known, are a waste of personnel, and I believe we can handle it so that there will be no large number. Heretofore, there has been a replacement pool in Brook Army Medical Center for all medical department personnel. They merely sign their own papers; they never arrive there. They have their assignment. They have to make an assignment when they are accepted. Their orders reach them, and they go to their permanent assignment. Prior to going to an assignment, unless they are waived, they remain in the pool and are put in the pool after that unless their assignment has been made from the school prior to their graduation. That's the only pool I approve of.

RESTRICTED

RESTRICTED

REAR ADMIRAL RAULT: May I ask you a question?

Do you keep them for some period of time?

MAJOR GENERAL SMITH: They never go there unless they are sent there for school -- merely a paper transacted.

BRIGADIER GENERAL KENNEDY: Just keep them on the morning report.

MAJOR GENERAL SMITH: They are awaiting assignment and assigned to the pool. They are called directly from home to the active duty station unless they are called there to wait for the beginning of school. Then they are automatically assigned to that pool when completing a course, unless they have already arrived for assignment to station.

REAR ADMIRAL ANDERSON: Did you have experience with replacement pools of dental officers during the war?

MAJOR GENERAL SMITH: Not replacement pools as such because we were not allowed a replacement pool in the European Theater where I served. There, any officer coming in would go to a camp and wait assignment at that camp. Some of them referred to it as a replacement pool, but they would all be assigned to one particular camp to have a place for billeting them and for handling paper work; and, if we got their names soon enough, why they were immediately assigned to installations; but, if we didn't have the advance papers on

RESTRICTED

RESTRICTED

them, then they went to this camp and were assigned to a pool if you call it that.

REAR ADMIRAL ANDERSON: That was the situation as far as dental officers were in the Pacific. We never had enough dental officers out there to make a pool.

BRIGADIER GENERAL KENNEDY: I haven't heard many criticisms from dental officers about pools as from medical officers. We had what we called working pools. If we had sufficient equipment there and sent a man in, he could go right to work while awaiting assignment elsewhere.

MAJOR GENERAL SMITH: On return to the United States when the emergency was over and large numbers were released, they were actually in pools or redeployment camps, they called them, waiting for transportation. We had large numbers, too, in that type of pool, but not as a pool for our own benefit other than for transportation.

REAR ADMIRAL BAULT: Those were really discharge camps more or less. We had the same thing. I forgot the name that we called them.

MAJOR GENERAL SMITH: In overseas stations, it was a camp, and we attempted there to have dental officers in the camp look after the personnel. It was actually a working organization; but, when they arrived at the port of embarkation, they were merely awaiting transportation.

RESTRICTED

RESTRICTED

REAR ADMIRAL ANDERSON: I think that the suggestions you have made are the solution of the replacement pool -- namely, that the officer who is awaiting assignment should be stationed at some unit where he can work in his specialty. It may result in overstaffing of the hospital of the unit, but that has far fewer disadvantages than placing him in some camp where he waits indefinitely for his assignment to come along.

MAJOR GENERAL SMITH: I am taking a lot of time on this. One other thing that we had in the several deployment camps that we had -- we would staff them with two dental officers as permanent staff, but there would be equipment for ten or twenty; and, as they were passing through while waiting at this camp, they were called into this clinic and put to work on their own personnel not completely staffed. So, as a consensus of the Committee, I would say that we are against pools as such.

REAR ADMIRAL ANDERSON: The next subject we are concerned with is redeployment and demobilization of personnel. There were many complaints from medical officers during the demobilization period. It was necessary to retain them in the service because the sick were not discharged as rapidly as the troops were demobilized, and it was necessary to have medical officers to take care of

RESTRICTED

RESTRICTED

patients even though the forces were being rapidly demobilized.

REAR ADMIRAL RAULT: May I add that that exists right today? We still have medical and dental officers from the ASTP and the V-12 program who are being held until demobilization is over -- nearly two years.

. . . Off the record . . .

REAR ADMIRAL ANDERSON: Another complaint concerning demobilization was the rather dull type of duty that the medical officers were called upon to perform over long periods of time in the demobilization centers, and a suggested remedy of that situation has been to rotate medical officers from duty in separation centers to other types of duty. In your experience, does this concern the dental officers?

REAR ADMIRAL RAULT: Absolutely! Our biggest complaint was from dental officers who did operative surgery exclusively, and that applies to pre-mobilization days, peacetime, and to postwar days. Recently, I put out a memorandum from the Bureau recommending that all of our people be rotated in one specialty or another so that they get diversified duties, not only for the lack of boredom that goes with that, but because of the experience they get to operate better when on independent duty.

RESTRICTED

RESTRICTED

BRIGADIER GENERAL KENNEDY: That applies, however, not only to demobilization, but right straight through. The man in demobilization does the same type of work that he did all through.

REAR ADMIRAL BAULT: That's right. That's the biggest complaint we had from dental officers -- none of the other things you spoke of. I think that applies for all three services -- the dull routine that they had to accomplish day in and day out, particularly in the training centers.

BRIGADIER GENERAL KENNEDY: Being chained to a chair doing amalgam silicates with a continual turnover of patients, one after another, the same sort of work day after day.

REAR ADMIRAL BAULT: However, it is very difficult to vary that routine too much because it is the bulk of the work that the patients need at that age when they come into the service. I doubt very much if, in the next war, it will be much easier despite the plans you make.

BRIGADIER GENERAL KENNEDY: Ninety per cent of your work is right in that area, perhaps.

REAR ADMIRAL ANDERSON: We return to (c) -- general policies relative to assignment of medical personnel, including the use of recognized specialists and consultants.

RESTRICTED

RESTRICTED

MAJOR GENERAL SMITH: In that connection, that policy in the planning of the Army of professional personnel, not only professional but all Army -- once a man becomes a specialist, his career planning is attempted to keep him in that specialty. When you transfer him, you try to keep him in the particular line of work that he is in now. That's pretty fancy, but that's the career planning system throughout the Army for all specialists.

REAR ADMIRAL ANDERSON: That's one of the complaints of many discharged medical officers, that they were assigned to billets where they were not employed as specialists. It was not the policy at all, of course, to assign them that way; but, due to faulty classification records or necessity of the situation, there was a good deal of dissatisfaction. The medical officers were assigned to billets where they were not employed in the practice of their specialty.

REAR ADMIRAL BAULT: We had that same problem in the Dental Corps, but the necessities are such that we can't employ all the specialists in the fields that they would like to get into. As I said before, the age group requires a lot of fillings and operative dentistry. Some survey made some time ago of the dental profession indicated that 25,000 of 70,000 said they were oral surgeons. We couldn't employ them in that ratio in the service and then have them left feeling

RESTRICTED

RESTRICTED

they were expected to do things that were in the general practitioner's field, whereas I know all these people didn't all specialize outside.

MAJOR GENERAL SMITH: If you get the rating system, that will take care of that.

BRIGADIER GENERAL KENNEDY: The rating system on what the man says himself has some things that are not too good. If they could be rated some way by their own state society, you would get a better rating than a man would put down himself. You will get at least one-third of them who will say they are oral surgeons if you accept that.

REAR ADMIRAL RAULT: I think it would be necessary to work out -- that's why I asked that question at first -- a classification that will have to be done nationally. I wouldn't want to leave it to the state society. Maybe you have something like a procurement assignment service who would collect data that would be sent to the national office, but to leave it to the society, I think, would be a pretty weak link in the chain.

. . . Off the record . . .

REAR ADMIRAL ANDERSON: One other feature about assignment of medical officers that has caused some complaint is the requirement that they perform non-professional duties.

RESTRICTED

RESTRICTED

In a questionnaire which was addressed to a large number of discharged medical officers by the Bureau of Economic Research of the AMA, the discharged Army medical officers estimated that 37 per cent of their time was devoted to non-professional duties. The discharged Navy medical officers estimated that 28 per cent of their time was devoted to administrative duties. Do you have that difficulty to contend with in the assignment of dental officers?

MAJOR GENERAL SMITH: A very big difficulty in the combat units. For instance, when they go in combat, it has been the argument of many line, and I might say other, officers that, during combat, it is no time to do dentistry. As a result, the dental officer had other duties entirely in many instances. In the European Theater, actually when it was feasible, we took the officer from the unit and put him in the pool at headquarters if he wanted an assignment at headquarters, but they would be detailed where they could do certain types of dentistry. They would be running first-aid stations and every type of work except the work for which they were professionally trained to do. I would say 90 per cent of their duties during combat were other than strictly professional dentistry duties.

REAR ADMIRAL ANDERSON: Do you think that's a necessary feature of the work of the dental officer in the combat

RESTRICTED

RESTRICTED

area?

MAJOR GENERAL SMITH: No, sir; only in extreme emergency, not routine.

REAR ADMIRAL ANDERSON: Do you have any suggestion about how it can be avoided?

MAJOR GENERAL SMITH: Well, you could have to get into generalities on that. I would prefer to cite a specific case of a division. We had a division in combat where the officers were assigned to end small units. When they were actually facing the enemy or in real combat, they were usually put in first-aid stations as admission officers and that type of work. As we have tried to do in the recent attempted table of organization, we have tried to take those officers out and place the entire group at division headquarters to be sent out when and if needed to perform requested duties. That's one instance. The same thing throughout the combat units -- form groups or cells of dental personnel as you now have in the Army, certain auxiliary surgical groups, oral surgery teams, etc., have them go to various places and move from the direction of the top level of that particular unit in places wherever they would be needed. That would be a solution, and was a partial solution in the European Theater -- not have them assigned as individuals to combat units, but in cells controlled by the headquarters of

RESTRICTED

RESTRICTED

that particular division.

REAR ADMIRAL ANDERSON: The dental officer would perform non-professional duties, but under the control of higher echelons.

MAJOR GENERAL SMITH: If his own organization were not in a position to receive professional work, he would be doing it on someone else.

REAR ADMIRAL RAULT: In the early days of the war, didn't a lot of dental officers get killed because they were put in charge of litter bearers or in front lines, and you lost their professional services.

MAJOR GENERAL SMITH: Large number all during the war were killed. That's in combat. Anybody is liable to get killed, but they were not utilized as professional men.

COLONEL POEL: That's utter wastage of manpower.

REAR ADMIRAL RAULT: That's the criticism I heard of the Army dental officers in the field. I don't know that this might have happened with our Marines, too, but I haven't heard of it so much. So, if they were sent ashore in Guadalcanal with the first wave, they generally took over some duties that probably should have been done by a line officer; but, as a whole, I don't think that charge was leveled at the Navy because we weren't in a position to commit the offenses.

RESTRICTED

RESTRICTED

MAJOR GENERAL SMITH: I think that could be corrected, as I said, on the division level, and has, in my opinion, been corrected, placing all the dental personnel at the division level at division headquarters to be put out as cells or units where they can perform professional duties; when that ceases to be possible or practicable, put them some place else because only a small percentage of the personnel of a division are in combat at the same time.

BRIGADIER GENERAL KENNEDY: In the Air Force, we didn't have so much of that because they flew from great distances, and our people didn't fly with the planes. Our dental officers stayed back and were able to work rather continuously. However, I don't think we should have permanently assigned, to any small organizations, dental officers, not to Air Force groups or Air Force wings which would be compared to battalions or regiments, but have them on the top level under the staff dental surgeon; let him decide where they should be utilized. When an Air Force group is in combat and patients are not available, he can pull the dental officers out and place them in other areas where they can be used.

COLONEL FOHL: You plan to use cellular teams from higher level.

RESTRICTED

RESTRICTED

BRIGADIER GENERAL KENNEDY: That would be my idea in the matter.

MAJOR GENERAL SMITH: In the parachute regiments, airborne regiments, dental officers travel right with the men. That's a waste of professional men because they can't take their equipment in the first place and can't do dental work without the equipment. They actually jumped with them during the war or went in on the gliders with their units. That, I think, should be corrected by the call at headquarters of the unit and go at such time as they are needed for professional use.

REAR ADMIRAL ANDERSON: Are there any other comments about assignment of dental officers?

BRIGADIER GENERAL KENNEDY: We didn't mention consultants a while back. How about plans on consultants, utilization of consultants in emergency to check on and supervise various installations? What is the medical plan on that?

REAR ADMIRAL ANDERSON: Well, the comments that we have received all recognize the value of consultants in the offices in the areas. They are necessary and contribute greatly to the quality of professional service that is rendered. There has been some comment about consultants at different levels, I think, with the conclusion that the

RESTRICTED

RESTRICTED

consultants should be attached to high echelons rather than have consultants attached, say, to lower levels where they are not in the position to render service over greater areas, say, as a consultant at the Army level where he can visit all the units in the area within a consultant's capacity. But the interviews and letters we have had all indicate that the consultant is invaluable in the forward area.

BRIGADIER GENERAL KENNEDYBECK: How about the zone of interior?

REAR ADMIRAL ANDERSON: That applies also in the zone of interior.

BRIGADIER GENERAL KENNEDYBECK: With frequent visits to installations, etc. I think in this last war, as far as dental officers were concerned, we had a few, but they would come into the station, probably stay half a day, and attempt to evaluate prosthetic service. They didn't get a true picture, and local personnel didn't get much help. They didn't stay long enough. Those are the comments I got from my people. There weren't enough of them, nor did they come around as frequently as they thought they should.

REAR ADMIRAL ANDERSON: Are there other comments on this?

RESTRICTED

RESTRICTED

REAR ADMIRAL RAULT: I would like to say the most critical problem facing the dental services of all three outfits is the lack of trained prosthetic dental technicians in our organized reserves. I don't know how we are going to secure these people or how we should catalog them. At the present time, they are training a tremendous number of them in the United States, and there will be a great excess as a whole, but it is difficult to grade them according to ability as you are trying to do for medical and dental officers and other personnel. There should be some means of classifying these people and cataloging them because they are just as important to relieve the dental officer of laboratory procedure so his services can be utilized at the chair.

BRIGADIER GENERAL KENNEDY: And earmarking them, too. A lot of those were used for other duties during this last war.

MAJOR GENERAL SMITH: We had difficulty in spotting the man and getting him cataloged as a technician and the like when he was drafted. The difficulty was in getting him assigned to the medical department. If he had some other qualifications that the line officers liked, they got him first; they got the first shot at him. A recommendation was made to the effect that passages of that type should be

RESTRICTED

RESTRICTED

sent to the medical department to the capacity they could handle.

BRIGADIER GENERAL KENNEDY: Why couldn't a survey of those individuals be made? They are a subprofessional group.

MAJOR GENERAL SMITH: The same thing would apply to your laboratory technician, your bacteriologist, and your pathologist.

REAR ADMIRAL RAULT: All those trained technicians. Prosthetic technicians are over the age group that fall into the category under the draft act that is proposed now -- 26 years of age. It takes fifteen years, perhaps, for these men to become competent in bacteriological or prosthetic dentistry. We have to draw those from the higher age group. That's the reason we can't enlist them in the reserve. They feel that, in time of emergency, they are going to be left out. I don't remember the exact figure, but we have about 70,000 reserve dental officers, and I don't think we have more than 90 prosthetic dental technicians in our reserve.

MAJOR GENERAL SMITH: I think, in the over-all thing, speaking to Admiral Rault, that possibly there would be, in the entire emergency, an actual draft of all manpower. Isn't that what this is considering more or less? And you can get

RESTRICTED

RESTRICTED

that type of man. The only thing I can see in that, if they are brought in, is that a recommendation should be very strong that they are not to be placed as gunners when they can do other work if they come in now. You have no way of getting them in. That's another story.

REAR ADMIRAL RAULT: Those people trained outside are often specialists in one field, and you have to put all these various parts of technicians together to make a whole. Isn't that your experience, General?

MAJOR GENERAL SMITH: The trouble is that they were assigned to line units somewhere. They couldn't use their mechanical ability in training. They would be assigned as radio mechanics and anything with mechanics. They would catch them, and the medical department wouldn't get them in unless they could go out, spot them, and arrange for individual transfers.

BRIGADIER GENERAL KENNEDY: Many times in the Air Force, if he was handy, if they found a mechanical job on the airplanes which would give them a higher rating and a better chance for promotion than in the dental laboratory, they would hide their qualifications some time. If they were interviewed, they wouldn't want to come to the dental service because their chances were better where they were; their opportunities were greater. So, if we could

RESTRICTED

RESTRICTED

earmark those fellows some way -- I think there are enough available technicians if we could just earmark them.

MAJOR GENERAL SMITH: More than you can ever use will be drafted if you have a real, all-out emergency.

REAR ADMIRAL RAULT: Yes. That's a very difficult group. They are unlicensed and hard to classify.

MAJOR GENERAL SMITH: Auto mechanics -- they get plenty of those. They go into that channel. The trouble is getting them in the medical department and get them assigned to the dental department. That's the biggest difficulty we had.

I think that about covers all that. There is no use repeating it as I can see.

REAR ADMIRAL ANDERSON: Yes. I still don't have an idea of what the correction is.

MAJOR GENERAL SMITH: Merely in the over-all planning, if the man has a specialty, if he is a laboratory, bacteriological, or dental technician, he should be assigned, and certainly be given an opportunity to be assigned, to that department. That's the only suggestion I have.

REAR ADMIRAL RAULT: That would go back to my original suggestion that the manpower resources board be organized, and I have seen a written suggestion to this

RESTRICTED

RESTRICTED

effect -- it is not original with me -- that the American Medical Association, the American Dental Association, and the various hospital associations in the United States be represented on that board -- I don't know what the exact name is -- and similar groups. These groups would each look after the manpower situation in that and recommend to the National Resources Board what should be done.

Now, there are bonafide prosthetic dental laboratory organizations in this country -- one or two, anyway -- that are really recognized as being dependable, and I know the secretary of one of those groups is coming down to talk to Selective Service within the next week or so on some of the problems I have just brought up.

REAR ADMIRAL ANDERSON: I think the difficulty you mentioned a little while ago, about the present draft law not including age limits, which would really bring prosthetic technicians into the service. It would be modified in case of emergency, and this is a peacetime draft and is only to obtain enough personnel for peacetime requirements of the services. But, in case of national emergency, the age limits would be raised, and that would include the group of technicians that you have referred to.

BRIGADIER GENERAL KENNEDY: If they are going to consider dentists in all age groups, then they should

RESTRICTED

RESTRICTED

consider these men, certainly, in all age groups.

REAR ADMIRAL ANDERSON: If there is no further comment, there is one last subject -- the chief points or circumstances within the military structure contributing most to the apparent disaffection of medical personnel. We have referred to that a number of times. Do you have any additional comments on that?

MAJOR GENERAL SMITH: I think you can boil that down. We have discussed that in many instances, and there is no formal committee recommendation on that. Living conditions, separation from families, and the fact that their pay is not comparable to the man in civil life are three broad subjects which would cover most of the adverse comments -- particularly the housing and the pay. The third one, separation from families, you cannot avoid unless they have housing and sufficient pay to keep an establishment.

REAR ADMIRAL ANDERSON: Any further comments?

BRIGADIER GENERAL KEMMECK: Another one is specialization. Of course, we have touched on that -- not being able to have specialization training professionally. We commented on that earlier today.

COLONEL POHL: I noticed, in many of the replies we have, that there are many complaints on relative rank

RESTRICTED

RESTRICTED

with the line, and I felt, in my observation, that the Dental Corps has had a rather rough time in rank.

MAJOR GENERAL SMITH: That's one of the big objections in getting them to come back on active duty at this time.

BRIGADIER GENERAL KENNEDY: The T/O limitation on rank, especially overseas, in the Air Force where a man can only be a captain regardless of his ability is a big gripe among Air Force people. Men who came in later, classmates, who stayed in the states would go out as lieutenant colonels because they happened to be in the spots where they could be promoted, while the ones who went overseas earlier would be captains.

MAJOR GENERAL SMITH: One of the outstanding examples of that in the Army is again with your combat organization. In a division, which is a larger unit, the highest ranking officer is a major. During the last war, there was one. The highest rate the others could attain was captain unless they were transferred to some other unit. The next promotion in line is that he jumped from major to colonel. So the highest rank a man could be in the combat organization is major.

We are attempting to correct the tables of organization to take care of that, but there is no place to make that

RESTRICTED

RESTRICTED

uniform. The result is: when you asked for a transfer or rotation, you couldn't ask for a man by name in an attempt to rotate him to the hospital. You had to send him through Army headquarters, and the combat unit could pick out the less desirable, let's put it that way. As a result, the good men were stuck with no opportunity for promotion even to the grade of major unless the major were transferred or something else happened that there was a vacancy -- then one out of the eighteen in the division; no opportunity to be a lieutenant colonel at any time in any Army organization; I mean combat Army, field Army. That was one of the big objections to promotion, and then the table of organization limitations which apply to everybody. I think that applies equally to manpower except in this one instance in the Army in a combat organization.

HEAR ADMIRAL RAULT: The Navy did not have that problem because we have the running-mate system. All staff officers, medical and dental officers, go up with the running mate in the line. In one or two instances that was discarded during the war, but very, very little, and it didn't become a problem at all.

HEAR ADMIRAL ANDERSON: In the Naval organization, our personnel allowances, which correspond to your table of organization, are more elastic. The personnel allowances

RESTRICTED

RESTRICTED

of a given unit may call for a lieutenant on a ship. You may find a lieutenant commander serving. Is that true?

REAR ADMIRAL RAULT: Right.

BRIGADIER GENERAL KENNEDY: If he were a lieutenant there, could he be promoted to a lieutenant commander?

REAR ADMIRAL ANDERSON: Only promoted when his running mate is eligible for promotion.

. . . Off the record . . .

REAR ADMIRAL ANDERSON (continuing): I am unable to see how any equitable system of promotion can be established where promotion depends on vacancies in the table of organization. It just can't be done.

MAJOR GENERAL SMITH: And if you have a job, for instance, that warrants a promotion, and you would be taking a skip of personnel to fill that. It would work all right if the man were in the job and qualified for it. If there is a vacancy, he can be promoted.

REAR ADMIRAL RAULT: We took care of that in the war in rare instances where people got spot promotions. That was very unusual. While they occupied that particular position, they held a spot promotion; when they transferred out of that, they went back to permanent rank.

REAR ADMIRAL ANDERSON: Most spot promotions were reserved for officers assigned to high positions, staffs

RESTRICTED

RESTRICTED

of commanders.

MAJOR GENERAL SMITH: I don't think it could be equalized due to the different systems of promotion.

BRIGADIER GENERAL KENNEDY: There has been some criticism from the Navy officers of the Dental Corps who have been working side by side with Army officers that the Army officer can be promoted after one year, while the Navy officer goes through two years now without any promotion. Each of them work side by side.

REAR ADMIRAL ANDERSON: That's in the lower rank.

BRIGADIER GENERAL KENNEDY: That's in the rank of junior lieutenant.

REAR ADMIRAL BAILEY: We took that up, incidentally, with the Navy Department, and the official reply was that they believe in the long run that our people would be as well off, if not better off -- and I am inclined to believe it is so -- with the running mate principle. That was the reply officially.

. . . Off the record . . .

REAR ADMIRAL ANDERSON: Is there anything further?

REAR ADMIRAL BAILEY: Do you want to put this in the record: here is a reference that will be in the Bureau of Medicine and Surgery Manual of the Medical Department of the Navy --

RESTRICTED

RESTRICTED

"4142.2 An officer on the active list of the Army of the United States and an Army aviation cadet serving in locality where Army dental service is not obtainable shall be furnished dental treatment, both out patient and in patient, at Navy dental facility on same basis as dental treatment is accorded Naval personnel.

"4143.2 Enlisted persons on the active list with the Army of the United States shall be furnished dental treatment at Naval dental facility in accordance with paragraph 4142.2."

We were going to recommend -- I didn't have an opportunity to discuss this with our Committee -- that the Army regulations be made parallel to that recommendation. I know that, at the present time, the Army and Navy both are taking care of each other's personnel, but this would clarify it in the regulations.

MAJOR GENERAL SMITH: I may add that that has been routine for the past five years in Army installations for Army dental personnel to take care of Navy personnel -- not only personnel, but dependents also.

REAR ADMIRAL RAULT: Let's not put that in the record. (Laughter).

REAR ADMIRAL ANDERSON: Before you gentlemen leave, for the record would you please give your names and a brief

RESTRICTED

RESTRICTED

statement of your service?

MAJOR GENERAL SMITH: Thomas L. Smith, Major General,
Chief of Dental Service of the Army.

REAR ADMIRAL RAULT: Rear Admiral C. V. Rault, IC,
USN, Assistant Chief of the Bureau of Medicine and Surgery
for Dentistry, and Chief of Dental Division.

BRIGADIER GENERAL KENNEBECK: Brigadier General
George R. Kennebeck, Dental Corps, USAF.

. . . The meeting was adjourned at 3:10 p.m. . . .

* * *

RESTRICTED

RESTRICTED

The NATIONAL MILITARY ESTABLISHMENT

OFFICE OF THE SECRETARY OF DEFENSE

SUBCOMMITTEE ON THE EMPLOYMENT OF

MILITARY MEDICAL RESOURCES

Friday, 14 May 1948 - Room 3D675 - 3:05 p.m.

APPEARING: CAPTAIN LLOYD R. NEWHOUSER, (MC), USN
Chairman, Subcommittee on Training and
Education of Medical Department Personnel

WASHINGTON, D. C.



NO. 220

Conference Reporting Section

Reported By: V. Savonis

Extension 5167 Room 3C717

RESTRICTED

RESTRICTED

OFFICE OF THE SECRETARY OF DEFENSE
SUBCOMMITTEE ON THE EMPLOYMENT OF
MILITARY MEDICAL RESOURCES

Friday, 14 May 1948 - Room 3D675 - 3:05 p.m.

In Attendance:

Rear Admiral T. C. Anderson (MC), USN, Chairman
Brigadier General Jos. I. Martin, MC, USA, Member
Colonel Louis K. Pohl, MC, USAF, Member

Appearing:

Captain Lloyd R. Newhouser, (MC), USN, Chairman
Subcommittee on Training and Education of
Medical Department Personnel

* * *

RESTRICTED

RESTRICTED

. . . The meeting convened at 3:05 p.m., with
Rear Admiral Anderson presiding . . .

REAR ADMIRAL ANDERSON: Captain Newhouser, we have been directed to discuss with your Subcommittee the subjects which are more or less common to both committees chiefly in order to harmonize our views and provide recommendations to all the Committee that are not at too great variance.

The first subject that we have which we think overlaps with the work of your committee is (b) in our list here, "Professional and military emergency training programs within the Armed Forces."

Now, our committee have considered this subject in relation to mobilization. It includes the emergency training in case of another national emergency, and we have considered the subject from the standpoint of military and professional training necessary for doctors, for nurses, and for enlisted members of the medical services who are called into the service in case of war.

The question comes up whether doctors need basic military training. There was criticism about doctors being assigned to camps and going through possibly months of military training and then when assigned overseas were employed in hospitals where it seemed to them at least the military training they had received had little bearing upon what they were asked

RESTRICTED

RESTRICTED

to do during the war.

I don't know that your committee have considered that side of the question, but we would appreciate an expression of opinion as to what your idea is about the amount of basic military training that the average physician should receive when called into the service; and also where that basic military training probably could best be given.

CAPTAIN NEWHOUSE: We did not make any definite recommendation on that line, although we discussed it at some length. We questioned whether or not that was within our province.

The consensus of our group was that it would be very advantageous, such as the Army Field Service School, or its equivalent, and that it would be advisable if all medical officers could attend for a period say of approximately a month to get some slant on what they might encounter, and that's about as far as we went with it. We didn't make any definite recommendations, and whether we do in our final report, it is questionable. It will depend on how much has been covered by some other subcommittee.

REAR ADMIRAL ANDERSON: What would be your recommendation about professional training that should be given to physicians when called into the service?

CAPTAIN NEWHOUSE: Well, the majority of the doctors

RESTRICTED

RESTRICTED

called into the service had had a reasonable amount of professional training, and I don't believe that it will be necessary to give them other than short courses. For example, you may have a fairly good general surgeon who has had no traumatic surgery. You might want to give him a short course in traumatology. There will be selected cases of that type, for example. Others, who have had a certain duty in civilian life, State, Public Health jobs, and so forth, we might want to give them short courses in preventive medicine. For the most part, they would be very short courses. They would already have a background in that general specialty, but you might want to teach them just the military phases of it. In other words, they would be short courses and not long courses.

REAR ADMIRAL ANDERSON: What would you recommend about the training necessary for nurses when brought into the service? Should they have some military instruction, or should they have professional training?

CAPTAIN NEWHouser: I don't feel that they need professional training. They need indoctrination training primarily. The nurse has already trained in the care of patients, and that's what we will want most of them for. She has had plenty of experience in that, but she must find her way around in an Army or Navy installation. I think we would expect quite a lot from her if we expect her to do it the first

RESTRICTED

RESTRICTED

week she is on duty.

BRIGADIER GENERAL MARTIN: Off the record --

. . . OFF THE RECORD . . .

CAPTAIN NEWHOUSER: There are exceptions. I should think that nurses who will be on duty on evacuation flights should have some training other than indoctrination. I am not an expert along that line at all.

BRIGADIER GENERAL MARTIN: That's being done.

CAPTAIN NEWHOUSER: But that would seem only logical.

BRIGADIER GENERAL MARTIN: It was done during the war.

REAR ADMIRAL ANDERSON: Will you outline your idea of what training the enlisted men of the medical service should have when inducted into the service?

CAPTAIN NEWHOUSER: Well, I think all enlisted men should have an understanding of what we call the boot training --I have forgotten what the Army calls it, basic training, I believe--to orient them, acquaint them with service terminology, service conditions, they have to change their mode of living considerably; then I think that they--speaking of hospital corpsmen--should receive training in Medical Department activities, such as nursing, the elementary pharmacy, first aid, the various things that I think the Army and Navy teach all enlisted men.

Then I think we certainly want to select the most

RESTRICTED

RESTRICTED

promising of that group for specialized training. In other words, men qualified for independent duty with the Navy, submarines, and so forth; if it's Air Force, it will be with certain units of the Air Force; and I don't know conditions in the Army. Our Committee didn't think the Army had so many places that they would use--what we call men qualified for independent duty, as perhaps the Navy and Air Force would use.

That was the opinion of our group; but the representatives of the Air Force thought they had a very, very definite need of highly-trained enlisted men--what we call men qualified for independent duty, and they believe it strongly enough that they would like to send some men to our schools when it's possible.

REAR ADMIRAL ANDERSON: Are there other features of this training program that we should discuss? I notice that their precept includes joint utilization of service schools, coordinated post-graduate training, common bulletins -- is that included in your precept?

CAPTAIN NEWHouser: Yes, sir, I believe it is, bulletins.

REAR ADMIRAL ANDERSON: Training manuals, and so forth, as they apply to both commissioned and enlisted and civilian components, joint use of civilian consultants. I

RESTRICTED

RESTRICTED

think possibly we might ask what the Committee have decided about the employment of consultants. That's one of our topics here.

CAPTAIN NEWHOUSE: I would like the first part to be off the record.

. . . OFF THE RECORD . . .

CAPTAIN NEWHOUSE: In the first place, we cannot have common utilization of consultants because our training hospitals are not located in the same areas. The only possibility would be the Letterman General Hospital and the Oakland Naval Hospital. One hospital is at the end of the Golden Gate Bridge and the other one is out at San Leandro, many miles away.

These consultants are very busy men. They don't want to spend more than two afternoons a week at the most in connection with training medical officers of the armed forces. Joint utilization would mean they would have to spend four afternoons a week, let's say, or instead of one afternoon a week, they would have to spend two afternoons a week. They are unwilling to do it.

Just taking Letterman General, because that is one of the few places we can use as an example, you might say: all right, your residents come over to Oakland one time. Our residents will go over to Letterman General the next time.

RESTRICTED

RESTRICTED

You have from an hour to an hour and a half haul between the two hospitals.

There is a lot of work to be done in hospitals today and there isn't the time. That means too much loss of time. So the joint utilization of consultants is and will continue to be practically nil. I don't see how it can be otherwise.

Admiral, you see this consultant situation. You are located at the Medical Center. Wouldn't you agree that it's not feasible to have joint utilization of consultants?

Well, Army Medical Center and Naval Medical Center is another place where it might be done to a limited degree. I happen to know the Army consultants--a few of them are also Navy consultants. The Washington area is the best place where we can have joint utilization of consultants and yet it can't be too great even here. We have had, I believe, a couple of consultants drop out because they couldn't teach over at the Army Medical Center and teach at the Navy Medical Center at the same time. It took too much of their time.

REAR ADMIRAL ANDERSON: Would the joint use of consultants--I guess that's the way we would express it--under the present arrangement result in any economy from the standpoint of expenditure of funds?

CAPTAIN MEMROUHER: None whatsoever, because we can't expect a doctor to spend his morning at the Army Medical Center

RESTRICTED

RESTRICTED

and then his afternoon at the Naval Medical Center and accept \$50.00 for the day when he could do far better today by spending a couple of hours in his office. If we tried that we would both lose because they would refuse to be consultants for either service.

REAR ADMIRAL ANDERSON: Off the record --

. . . . OFF THE RECORD

CAPTAIN NEWHOUSER: I might add that that is also the opinion of our Subcommittee after considerable discussion. The only place that we might be able to utilize consultants for the Army or the Navy use our consultants -- there are times when consultants from the Boston area may be at a medical meeting in San Francisco, so they want a little something extra to do, and they will go into either the Army or Navy hospital and make rounds and give talks, but we don't pay them for it. We have no way of paying them for that because the services of our consultants must be anticipated in advance of the visits or we cannot pay them.

REAR ADMIRAL ANDERSON: I understand then that your Subcommittee have no objection to a given qualified consultant serving both the Army and the Navy? .

CAPTAIN NEWHOUSER: None whatsoever.

REAR ADMIRAL ANDERSON: But it's a matter of local arrangement.

RESTRICTED

RESTRICTED

CAPTAIN NEWHOUSER: That's right.

REAR ADMIRAL ANDERSON: That we should not adopt a policy and insist that the consultant--any given consultant serve both services.

CAPTAIN NEWHOUSER: I certainly think it would be a mistake.

COLONEL POEL: It seems to me where you have consultants at a high level making field trips you might utilize the same individual there where they go to a situation a few days and study a situation like a flu epidemic; might use joint individuals in that spot only, but that is a distinct type of consultant.

REAR ADMIRAL ANDERSON: I was going to say that is not in the teaching field especially.

CAPTAIN NEWHOUSER: I might say we have had to base all of our assumptions, recommendations on about three premises; that the services will continue as at the present time, there will be three services headed by the Joint Chiefs of Staff with medical representation, or there will be one medical service. Any recommendation we make, we have to think of those three possibilities, and we can't tell which may come about.

REAR ADMIRAL ANDERSON: I think that we might very well ask Captain Newhouser to give us some information under

RESTRICTED

RESTRICTED

this subject of medical logistics in military campaigns, about the supply of whole blood to theaters of operation in the war.

CAPTAIN NEWHOUSER: I might say that I was just asked the other day how much blood and blood substitutes would be needed in event of war. I am sure I would have no way of figuring it out unless I know a whole lot more than I know now.

REAR ADMIRAL ANDERSON: Off the record --

. . . OFF THE RECORD . . .

CAPTAIN NEWHOUSER: As you recall the Army, under General Rankin and Colonel Kendrick operated the program to ETO and I had a program in the Pacific. Conditions there were different. For example, we had to have lighter-weight containers. They used at first 50 per cent blood and 50 per cent diluent. When shipping to the Pacific our distances were great. We had to cut down weight all we possibly could. Therefore, we used the ACD solution, which is even today as good a preservative as we can find for whole blood. It cut our weight in half to the Pacific. We had to do it. Later, after they got a little better organized and didn't have quite the demand, they shifted to ACD also, but they had to rush the program considerably and the Army had a great stockpile of these bottles on hand and they were the thing to use so the program could be started almost over night.

RESTRICTED

RESTRICTED

It may be that the armed forces will not need a great deal of blood. Maybe the civilians will need the most, the majority of them. Certainly if five or six bombs are dropped on major cities, wherever they may be, there are going to be anywhere from 2-1/2 million to three million pints of blood needed within a matter of ten weeks, the majority of which will be needed within the first three to four weeks. That cannot be furnished unless there is an existing national program in effect before the disaster occurs.

Unfortunately at the present time there is considerable bickering between two national organizations, and what will come out of it, I don't know. Neither one is going ahead too well at the present time.

The peacetime function of the national program would be supplied where needed in community hospitals, and so forth, that do not have blood at the present time. There is probably not half the amount of blood furnished in this country today that should be furnished. Then if you have a good nucleus organization--as was shown on December 7th, '41--any blood bank that is then in operation can be stepped up tenfold during the night without greatly added personnel, and they can hold that pace for approximately three weeks, which gives you a chance to bring in additional personnel. If the next war is the type of war that we might possibly anticipate, a tremendous

RESTRICTED

RESTRICTED

amount of blood will be needed; by that, I mean the amount would run into millions of pints instead of the amount that we used in the last war. We collected 15 million pints over a period of almost over four years in the last war. That would have to be reduced to months.

HEAR ADMIRAL ANDERSON: Off the record --

. . . OFF THE RECORD . . .

HEAR ADMIRAL ANDERSON: One problem that the Subcommittee have discussed is the question of upon whom should the responsibility be placed for the operation of the whole blood program so far as the military services are concerned. Should it be made a special unit under the direct control of the Surgeon General, should it be assigned to the service of medical supply, or should it be made a part of a responsibility of the laboratory service? During the last war it was operated by a special unit, as I understand, directly under the Surgeon General's office.

CAPTAIN NEWHOUSE: Yes, sir.

I firmly believe that it is necessary to have a specialized group handling blood from the source until it's handed over to the hospital or activity that will use it.

BRIGADIER GENERAL MARTIN: Off the record --

. . . OFF THE RECORD . . .

CAPTAIN NEWHOUSE: During the early part of the

RESTRICTED

RESTRICTED

war we made plans for a separate transfusion service and outlined the whole program. It seemed to us that it was fairly easy to put it in effect in the Army because of your laboratory service and your organization. However, it was not very easily put into operation in the Navy at that time, and we were not too well organized along blood lines. A number of individuals had separate ideas. It was hard to get any one plan into operation, and this was taken before the National Research Council. They gave us a lukewarm blessing but didn't insist that we put it in operation, and it was left down the vine, so to speak.

. . . OFF THE RECORD . . .

REAR ADMIRAL ANDERSON: Thank you very much.

. . . The meeting adjourned at 4:00 p.m. . . .

RESTRICTED

RESTRICTED

The NATIONAL MILITARY ESTABLISHMENT

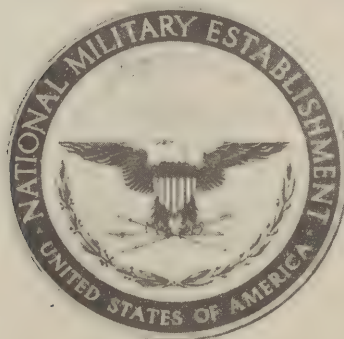
SUBCOMMITTEE ON THE EMPLOYMENT OF

MILITARY MEDICAL RESOURCES

Tuesday, 11 May 1948 - Room 3D675 - 10:00 a.m.

Appearing: Rear Admiral Paul M. Albright, (MC), USN
Chairman, Subcommittee on Programs for
Hospitalization

WASHINGTON, D. C.



NO. 211

Conference Reporting Section
Reported By: V. Savonis
Extension 5167 Room 3C717

RESTRICTED

RESTRICTED

OFFICE OF THE SECRETARY OF DEFENSE
SUBCOMMITTEE ON THE EMPLOYMENT OF
MILITARY MEDICAL RESOURCES

Tuesday, May 11, 1948 - Room 3D675 - 10:00 a.m.

In Attendance:

Rear Admiral T. C. Anderson (MC), USN, Chairman
Brigadier General Jos. I. Martin, MC, USA, Member
Colonel Louis K. Pohl, MC, USAF, Member

Appearing:

Rear Admiral Paul M. Albright, (MC), USN, Chairman
Subcommittee on Programs for Hospitalization

* * *

RESTRICTED

RESTRICTED

. . . The meeting convened at 10:00 a.m., with Rear Admiral Anderson presiding . . .

REAR ADMIRAL ANDERSON: We have been asked to confer with other Subcommittees in which there is overlapping. The subjects which we have been asked to investigate, which might overlap with the work of your Subcommittee, are listed in the letter that is addressed to you.

The first one is hospitalization and evacuation policies within the combat zone and evacuation to the communication zone, and to the zone of the interior.

General Martin is summarizing the comments and drawing up our ideas in regard to that particular subject. I think perhaps it would be best for you to give to Admiral Albright the ideas we have reached in regard to that subject.

The first question that occurs to me is: has your Subcommittee given consideration to hospitalization in the theaters of operation in case of a future national emergency?

REAR ADMIRAL ALBRIGHT: At the present time our Subcommittee on Programs for Hospitalization has been limited to existing facilities within the continental limits. It is anticipated, however, when this study has been completed that programs for hospitalization--that is, existing facilities--outside the continental limits will be considered.

RESTRICTED

RESTRICTED

REAR ADMIRAL ANDERSON: Will your Subcommittee give consideration to hospitalization in communication and combat zones in case of a national emergency?

REAR ADMIRAL ALBRIGHT: We hadn't anticipated doing that, no, in view of the fact that's a field operation and not a fixed hospitalization program now existing.

REAR ADMIRAL ANDERSON: Any action of our Subcommittee that we might take then would not concern the other Subcommittee. There would be no chance of conflicting recommendations inasmuch as that Subcommittee is not going to consider hospitalization in the forward areas in case of emergency.

REAR ADMIRAL ALBRIGHT: May I look over briefly the charges to our Subcommittee? I haven't re-read it recently, in view of the fact we have had plenty to consider within the continental limits with existing facilities. Roughly, I don't recall any such charge to our committee. I, however, have it with me, and I would like to glance over it hurriedly and see if there exists such a directive. Have you by chance seen our directive?

COLONEL POHL: Yes, sir, I have it here, an extract of what I thought were the precepts.

. . . OFF THE RECORD . . .

REAR ADMIRAL ANDERSON: Would you give Admiral Albright some of the considerations that we have given to

RESTRICTED

RESTRICTED

hospitalization in the field of the combat communications zone in order that should the committee consider hospitalization in those areas he will know what our committee feels about it?

BRIGADIER GENERAL MARTIN: Our concept of our part in this field is constrained to any future war effort. We have surveyed the problems which we can expect in this country as well as in any theaters of war in total war. It is our belief that the need for hospitalization in the zone of the interior must be provided for not only by civilian agencies, but it must be closely coordinated with military needs and resources.

I might ask has your committee gone into that field at all?

REAR ADMIRAL ALERIGHT: Do I understand you, General, to imply that in the event of total mobilization it is our responsibility to provide hospitalization for civilians in civilian communities?

BRIGADIER GENERAL MARTIN: The facts may call for that very provision in many areas, we believe. Off the record --
... OFF THE RECORD ...

REAR ADMIRAL ALERIGHT: Of course, I have very definite ideas on these. I am not speaking for the committee.

BRIGADIER GENERAL MARTIN: No, neither am I.

REAR ADMIRAL ALERIGHT: I am speaking for myself.

RESTRICTED

RESTRICTED

When the National Defense Act was passed a year ago, the Congress made very definite provisions for the National Military Establishment. Perhaps my interpretation of these provisions may be faulty.

Outside the Military Establishment of the National Defense Act we have set up the National Resources Board, which is a civilian-control outfit who, of course, evaluate all military plans and take into consideration what this country will be able to do with what resources are available in order to meet the strategical plan which is developed by the military.

In civilian life and away from military at the present time, we have, of course, many civilian organizations, including our American Medical Association, and in this group studies have been made and are continuing to be made relative to manpower particularly as applies to medical trained personnel, and also there are committees which have studied the problems of civilian hospitalization. I think it is known as the American Board on Hospitalization which have estimated the required beds needed in civilian communities throughout the country.

Personally, I believe it would be a terrible mistake to mix the military with the civilian in hospitalization questions. Military needs for hospitals should be developed by the military themselves. Who is there that is better qualified to do this than an expert in military medicine? If such

RESTRICTED

RESTRICTED

personnel are available in the military forces, they gain this knowledge by experience of many years' service, and they alone should be made responsible for the determination of the military needs, which I don't think should include civilian needs.

When these things are determined, I personally--again, these are personal opinions--believe that those matters pertaining to hospitalization and public health questions should not be questions of the military at all. Certainly we shouldn't, except in emergency, use military hospitals for civilian purposes.

HEAR ADMIRAL ANDERSON: To return again to hospitalization and evacuation policies in the combat and communication areas, I believe we can conclude that recommendations which we might make will not be at variance with those of this Subcommittee. Apparently they are not considering hospitalization in the combat and communication zones.

Now, to return again to hospitalization in the zone of the interior and to the details that have been assigned to our Subcommittee, construction, distribution, and staffing.

Construction is a matter under consideration by another subcommittee than that which you are Chairman, I believe?

HEAR ADMIRAL ALBRIGHT: That's correct, sir.

HEAR ADMIRAL ANDERSON: Distribution. Do you want to talk to him about distribution?

RESTRICTED

RESTRICTED

BRIGADIER GENERAL MARTIN: Off the record --

. . . OFF THE RECORD . . .

REAR ADMIRAL ALBRICHT: In the distribution of hospitals in the zone of the interior, our Subcommittee have felt that some coordinating agency would be necessary. It's our concept that your Subcommittee will submit the detailed recommendations as to distribution of the existing facilities, if I might put it that way, and that after the work of your Subcommittee is completed, there should be some coordinating agency which would continue to function in order to distribute hospitals of the three Armed Forces to effect economy.

We have felt that a joint medical board on a high level would be necessary not only for coordination and the distribution of hospitals, but for the coordination of other functions in the medical services, and the committee proposed to include in their recommendations that such a board be established.

We have considered that the board should be composed of either the Surgeons General and the Air Surgeon, or of representatives of these officers, and that they should function at the Joint Chiefs of Staff level, and that future hospital development would be coordinated by this board.

Our committee has felt the need of such a continuing board. On what level it should be, I am in no position to

RESTRICTED

RESTRICTED

say. Since the present board, however, reports directly to the Secretary of Defense, I would personally rather have the future board on the same level instead of the suggested joint-chiefs-of-staff level. That however may not be possible.

To clarify from our board's viewpoint the question of hospitalization or hospital provisions within the Armed Services, we appreciate very much the fact that the commodity of medicine, which is furnished to the armed services, and which includes of course hospitals, station hospitals, and dispensaries, have been located in the past in certain areas where this strategic support can be best given to the services.

There has been overlapping of such facilities, and I personally believe where such overlapping occurs, common utilization of such facilities wherever it can be justified, should be carried out.

In doing this we should not lose sight of the fact that future requirements may necessitate the use of such overlapping facilities which, for the time being, are inactivated, and we believe it should be an inactivation rather than the disposal of such facilities so that in the event of mobilization they may be available.

HEAR ADMIRAL ANDERSON: There is another feature on this question of duplication of hospital facilities that our Subcommittee have considered, that a thousand-bed general

RESTRICTED

RESTRICTED

hospital represents probably the greatest efficiency from the standpoint of size, and that a thousand-bed hospital might readily be expanded to two thousand beds, or possibly to greater capacity in the event of urgency; but that in considering the overlapping functions the medical departments should avoid combining hospital facilities in any given area that will require a general or naval hospital to operate continuously on a normal basis at much greater than a thousand-bed capacity.

. . . OFF THE RECORD . . .

HEAR ADMIRAL ANDERSON: Now, do we have any material in common concerning the staffing of military hospitals? Has your committee taken up the question of the staff of naval and general hospitals?

HEAR ADMIRAL ALBRIGHT: No, sir, not to this date. I noticed here -- have you got your finger on that one little thing? I might re-read one of these subcommittee things; but we haven't gone into it.

This paragraph 4 I think would cover that, which gives us -- let me hear your question again, please.

HEAR ADMIRAL ANDERSON: Off the record --

. . . OFF THE RECORD . . .

HEAR ADMIRAL ALBRIGHT: We haven't come to that, but may I read this paragraph here in our charge? "The Committee

RESTRICTED

RESTRICTED

desires also to explore the desirability and feasibility of developing to the highest practical degree greater uniformity and closer coordination among the medical services in administrative standards, policies, practices, procedures, and personnel requirements relative to matters pertaining to hospitalization."

Of course, we had looked at this from a broad viewpoint of joint staffing and whether or not it might be possible in certain institutions to reduce the over-all personnel in one or the other service so that he might be made available in a certain specialty for assignment to some other activity. We have discussed that -- if that answers your question.

REAR ADMIRAL ANDERSON: Does your Subcommittee subscribe to joint staffing of a hospital of one service by medical officers from the other services?

REAR ADMIRAL ALBRICHT: Again I am speaking for myself and not the Committee. I have talked a good deal on this subject to a great number of individuals, including the Surgeons General of the Army and the Navy and the Air Force Surgeon.

I personally am of the opinion that joint staffing is not only practicable, but I believe it to be advantageous in certain instances, particularly in such institutions where there is only one existing hospital but where personnel from

RESTRICTED

RESTRICTED

the three forces are present. I refer particularly in considering future plans for hospitalization in Guam, Adak, and Honolulu, where there is an overlapping of military requirements, but where economies can certainly be effected in building permanent institutions. Why should there be more than one permanently constructed hospital of a thousand beds, or less, if that is all which is required for the three military forces? For this same reason, I feel that there can be a true economy in personnel assigned to such institutions, a balanced staff from the three armed services. This would effect economy not only in construction, but also in the utilization of highly-trained medical personnel.

HEAR ADMIRAL ANDERSON: Should the staffs of naval hospitals and general hospitals be made up entirely of specialists and residents who are specializing, or should the tables of organization include a generous proportion of general professional men?

HEAR ADMIRAL ALBRIGHT: In replying to this question, I wish to state that I am speaking only from the viewpoint of a medical officer in the Navy.

In the Navy we have hospital ships and we have naval hospitals, including many dispensaries, some of which are comparable in size and mission to that of station hospitals within the Army. The only excuse for any shore activity within

RESTRICTED

RESTRICTED

the Naval Establishment is in support of the fleet. Medical men must be supplied to the fleet. When aboard ship or in the field of the Marines, the Navy expects its medical officers to be good all-around medical men.

In training naval medical officers at the naval medical school, these young doctors are taught how to do all types of emergency operations, including acute mastoid, acute appendix, and other surgical procedures. It is true that our naval hospitals and our naval hospital ships require in certain specialties a fairly well-balanced staff. This does not mean that these doctors are all certified by an American board in any one particular specialty.

It is desirable in teaching institutions to have a balanced staff of certified individuals, but certainly the needs of the Navy primarily are that of supplying medicine, including surgery, to those within the Navy, particularly the fleet.

REAR ADMIRAL ANDERSON: Again in connection with the staffing of hospitals our Subcommittee has discussed the administrative duties assigned medical officers and nurses particularly. In view of the acute shortage of this type of personnel in the event of an emergency, our committee feels tables of organization and personnel allowances should be modified with a view to assigning professional work only to

RESTRICTED

RESTRICTED

medical officers and nurses.

We feel that certain positions must be filled by medical officers, the commanding officer, the executive officer, and certainly the functions of the office of the chief nurse should be performed by a nurse; but there are many administrative duties in a hospital which we believe should be performed by medical service corps officers and other non-professional personnel.

I mention this conclusion as one that our Subcommittee will recommend for the information of your Subcommittee. Would your Subcommittee subscribe to such a change in tables of organization?

REAR ADMIRAL ALBRECHT: May I ask in what way isn't there being utilized to the fullest extent medical and nursing personnel within our hospitals?

REAR ADMIRAL ANDERSON: Well, I believe that the professional employment of doctors and nurses in hospitals is more carefully observed than it is in other medical units, particularly in field units during national emergency, and perhaps the question applies more to employment of those professional people during national emergency in field and smaller medical organizations.

There has been much comment by reserve officers on their employment in nonprofessional work. I believe that a

RESTRICTED

RESTRICTED

summary indicates that about 30 per cent of the time of medical officers in the Army was employed in administrative duties and about 26 per cent of the time of medical officers in the Navy.

REAR ADMIRAL ALBRIGHT: I believe you are speaking about the poll which was conducted by the American Medical Association directly after the cessation of hostilities in this last war.

REAR ADMIRAL ANDERSON: Yes.

REAR ADMIRAL ALBRIGHT: I reviewed the reports of this poll with a great deal of interest when they were published in the Journal of the American Medical Association.

I believe the criticism advanced by many medical officers who were in the armed forces at that time were made on the basis that they were not being utilized the greater part of their time within the service in their particular specialty. They also expressed certain percentages of inactivity without any occupation.

My personal opinion on this matter is that certain groups of medical officers comprising of staffs for proposed hospitals for over-shore assignment were held at ports of embarkation for certain periods of time before being assigned to their overseas stations. I appreciate only too well there was considerable loss of time while waiting for the progress of the war to reach a point where their services were required.

RESTRICTED

RESTRICTED

It is true they were in a stand-by status. This of course is a military requirement in that they have been held at a certain point so that they will be available to move forward when their services are required and when the military mission has reached the stage where their services will be needed. In other words, the necessity for having the right thing at the right place at the right time in the right amount is required in all military operations.

. . . OFF THE RECORD . . .

REAR ADMIRAL ANDERSON: The last one here is "Factors contributing to alleged overlapping." I think we have discussed that as far as your Subcommittee is concerned. It refers particularly to the distribution of hospitals.

REAR ADMIRAL ALBRIGHT: And I talked about that just a while ago.

REAR ADMIRAL ANDERSON: I have nothing further to bring up.

COLONEL POHL: I have two matters here, sir, if I may mention them?

REAR ADMIRAL ANDERSON: Yes.

COLONEL POHL: I have reviewed the replies to approximately 60 questionnaires, and I think we have touched on most of the subjects relative to agreement on size, the need for modern architectural design as compared with the

RESTRICTED

RESTRICTED

apparent lack of it, and we are thinking about what should be done for future emergency in the construction aspect. There were criticisms on location and on staffing. We haven't touched on the use of special treatment centers in the last emergency, and I believe it's up to us to make some type of recommendation in regard to such utilization.

REAR ADMIRAL ANDERSON: I think Admiral Albright has referred to --

COLONEL POHL: Not special centers in themselves for specific type cases.

REAR ADMIRAL ANDERSON: The problem is as to whether specialized hospitals should be established and utilized, or whether the treatment of the special types of cases should be included in the work of the naval or general hospitals.

COLONEL POHL: May I go on from there, sir?

REAR ADMIRAL ANDERSON: Yes.

COLONEL POHL: The difficulty that was encountered was the conflict of such special treatment centers with the hospitalization of the individual near his home because they didn't have adequate distribution of those special-treatment centers.

REAR ADMIRAL ALBRIGHT: What would be the opinion of your Subcommittee in regard to the use of special types of

RESTRICTED

RESTRICTED

hospitals?

REAR ADMIRAL ALBRIGHT: Well, there is certainly plenty of precedent for the establishment of special types of hospitals for the armed forces. For a number of years the Army and Navy General Hospital at Hot Springs, Arkansas was utilized by the Army and the Navy.

At Fitzsimons General Hospital at Denver for many years the Army took care of our tuberculous cases. On the other hand, during this past emergency when it was necessary for the Navy and I believe also the Army to get out of Saint Elizabeth's Hospital, the Navy did enter into an agreement or an arrangement with Fort Worth Public Health Service Hospital for the care of their psychiatric cases.

As I understand at the present time this will be a consideration which may have to be considered by our particular board in that it is my understanding that Fitzsimons will not have sufficient capacity for the care of tuberculous cases from the three armed services. In such event, it may be necessary to have another hospital to take care of cases of tuberculosis within the services.

In such case, I think it would be advisable to have one of these hospitals located at some distance from Fitzsimons General Hospital so that people from any particular part of the country could be hospitalized in such a hospital.

RESTRICTED

RESTRICTED

This could be carried further in the hospitalization of psychiatric cases, if we are able to so limit for the best utilization of highly-specialized personnel and with a joint use of a particular hospital for the psychiatric care of patients from the military services, that would be an economical factor.

COLONEL POHL: I have one last thing, sir, if I may. I wondered, Admiral, if you could give me some summary or concept of what your Subcommittee has considered with regard to specific needs of the Air Forces for hospitalization if that matter has come up at all?

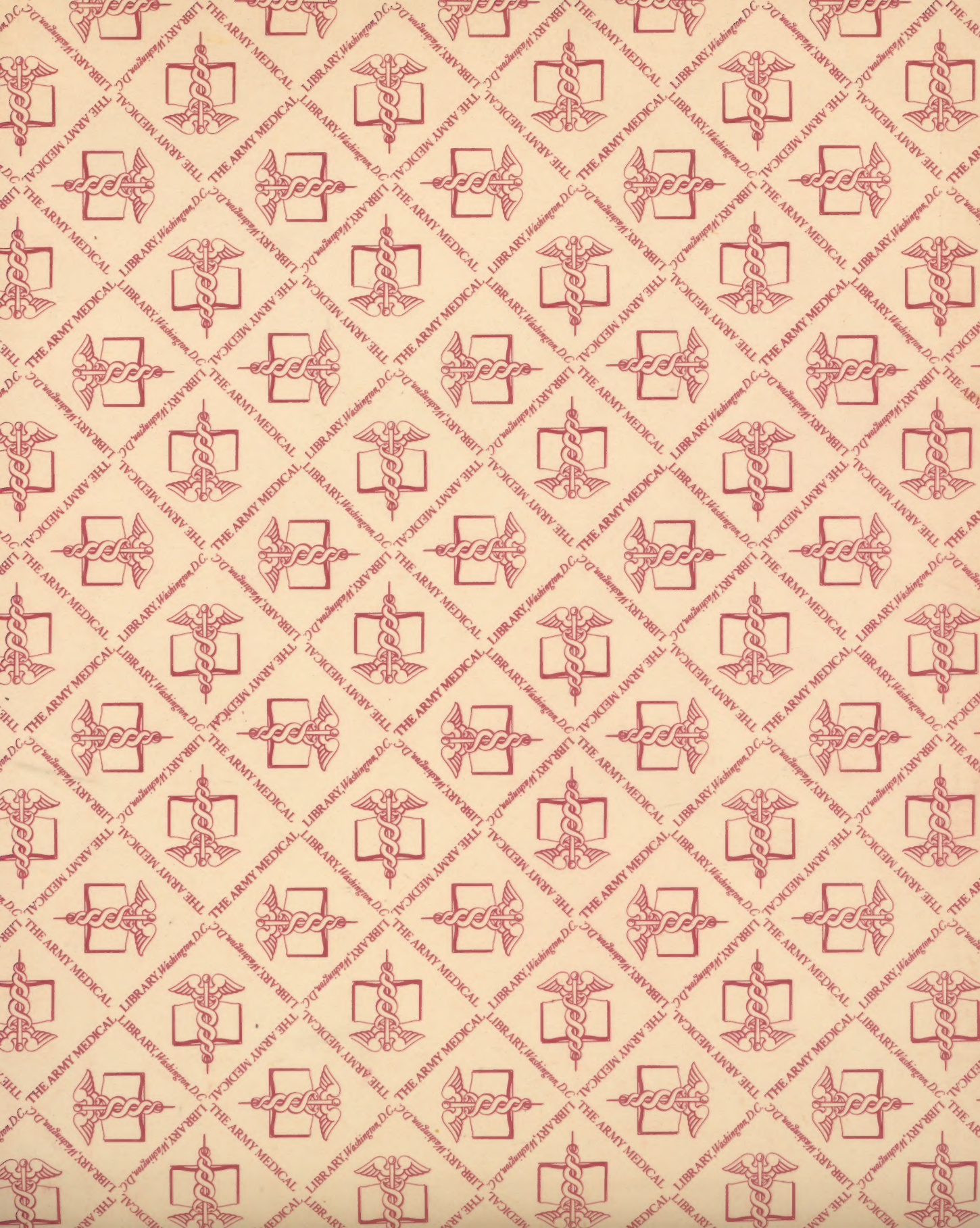
REAR ADMIRAL ALBRIGHT: Off the record, please.

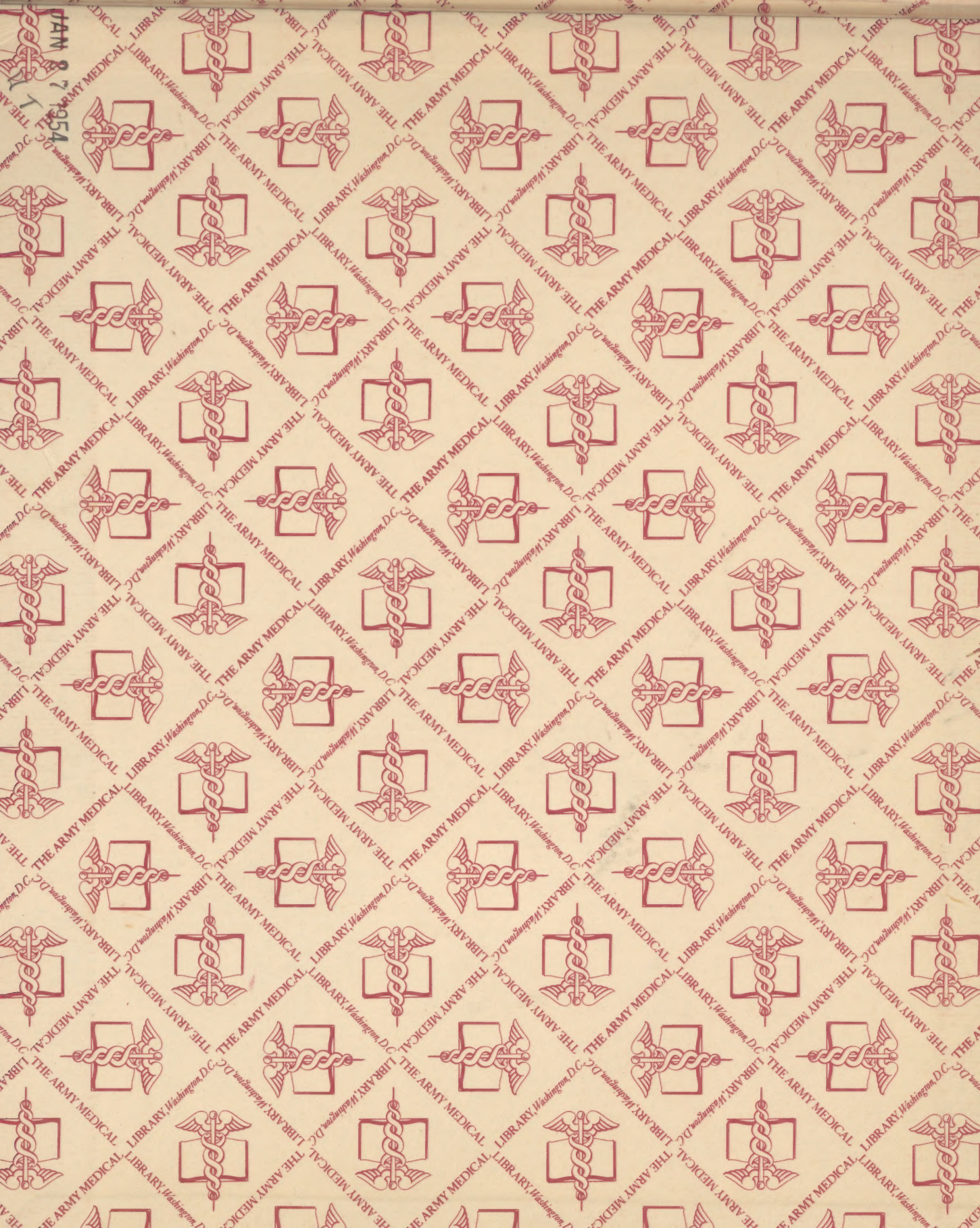
. . . OFF THE RECORD . . .

REAR ADMIRAL ALBRIGHT: Yes, consideration is being given for hospitalization of Air Force personnel.

. . . The meeting adjourned at 11:30 a.m. . . .

RESTRICTED





UH 390 U5678u 1948

14211400R



NLM 05100224 3

NATIONAL LIBRARY OF MEDICINE